

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: MN

APPLICATION YEAR: 2005

---

## **I. General Requirements**

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

## **II. Needs Assessment**

### **III. State Overview**

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

### **IV. Priorities, Performance and Program Activities**

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

### **V. Budget Narrative**

[A. Expenditures](#)

[B. Budget](#)

### **VI. Reporting Forms-General Information**

### **VII. Performance and Outcome Measure Detail Sheets**

### **VIII. Glossary**

### **IX. Technical Notes**

### **X. Appendices and State Supporting documents**

## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

The signed Assurances and Certifications are available upon request from:

Minnesota Dept. of Health  
Maternal & Child Health Section  
ATTN: Barb Kizzee  
PO Box 64882  
St. Paul, MN 55164-0882

Phone number (651) 281-9935

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. The Maternal and Child Health (MCH) Advisory Task Force provides a particularly significant source of input into overall state activities. This statutorily required advisory group is comprised of 15 members equally representing professionals with expertise in maternal and child health services; representatives from local public health; and consumer representatives interested in the health of mothers and children. The MCH Advisory Task Force is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children as well as priorities for funding of key maternal and child health activities and plays a critical role in the five year needs assessment process.

Each of the state's local public health agencies, through a formula distribution, receive at least two thirds of Minnesota's federal Maternal and Child Health Block Grant funds. The Local Public Health Grant Act which covers the distribution of the MCH Block Grant requires local public health agencies to establish local priorities based on an assessment of community health needs and assets; and to determine mechanisms to address the priorities and achieve statewide outcomes. The assessment, prioritization and planning processes all require community input.

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

MINISOTA. This Dakota Indian word meaning "water tinted like the sky" is what early Native Americans called what is now known as the Minnesota River and is the historical derivation of the state's name. Minnesota, a medium-sized state encompassing slightly more than 84,000 square miles, is located in the north central part of the United States. Also called "Land of 10,000 Lakes", it is well known for its scenic, cultural and recreational resources. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work.

Created as the Territory of Minnesota in 1849 and admitted to the Union as the 32nd state in May of 1858, the state's earliest economies centered on its natural resources of farming, logging and mining. Today, while it remains a major agricultural producer, Minnesota's economy is driven primarily by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade.

The workforce sustaining this economy comes from a population (2000 Census) count of 4,919,479 people, making Minnesota the 21st most populous state in the nation. Seventy percent of this population lives in one of the state's seven metropolitan statistical areas (MSAs). Residents of the seven-county, Minneapolis-St. Paul metropolitan area comprise 54 percent of the state's population, and 65 percent of the statewide population increase of 544,380 that occurred between 1990 and 2000 took place in this seven-county Twin Cities area.

Thirteen of the state's 87 counties had an increase of 10,000 or more people between 1990 and 2000 and another six counties experienced a population increase between 5,000 and 10,000 people. Ten of the eleven Minneapolis-St. Paul MSA counties had population increases greater than 10,000 and the eleventh county had an increase greater than 5,000. The state's population increase in the last decade is clearly concentrating itself in these eleven counties.

There are, however, counties that lost population between 1990 and 2000. Twenty-five of the state's 87 counties lost population during that time frame. Sixteen of these 25 counties either lost at least 5 percent of their respective 1990 population or saw the 1990 population decline by at least 1,000 residents.

//2004/ Minnesota, as is true for other states, has experienced significant budgetary, policy and program challenges over the last few years. The state's budget is based on a July-through-June biennium. For the 2002-03 biennium, (July 1, 2001 -- June 30, 2003), the budget deficit was \$1.95 billion accompanied by (a then) estimated structural deficit of \$2.5 billion for the 04-05 biennium. Awareness of these deficits did not occur until December of 2001; well after the 2001 Legislature, which adopted the 2002-03 budget adjourned in June of 2001.

When the 2002 Legislature convened in January of 2002 it chose to address only the SFY 02-03 deficit of \$1.95 billion. The then (early 2002) estimated SFY 04-05 deficit of \$2.5 billion was left for the next legislative session (January -- May, 2003) to resolve. By the time the 2003 legislature convened, the \$2.5 billion deficit had grown to \$4.5 billion. The 2003 Legislature chose to resolve the \$4.5 billion deficit primarily through program cuts. This resulted in reductions, in whole or in part, in almost every state program affecting maternal and child populations. Minnesota's publicly-funded health insurance programs such as Medical Assistance and MinnesotaCare, its TANF program (MFIP or Minnesota Family Investment Program), local public health funding, and the state's social services programs either had reductions in budget or changes in eligibility criteria. Most, but not all, of these changes take effect July 1, 2003.

It is this financial or budgetary backdrop that is defining decision-making on program activities ranging from family planning to WIC to CSHCN. //2004//

#### **A. Characteristics Defining The Needs Of The Entire State Population**

The health needs of a state's entire population can be described from a limited number of broad-based themes. For Minnesota the dimensions that best characterize the needs of all Minnesota citizens include a changing statewide demographic profile, poverty status, urban/rural population distribution, and disparities in health status among the state's various populations.

1. Changing Demographic Profile Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are small, the rate of change is not. As with other states, Minnesota also faces other significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population). These changes will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services. Specific examples or implications for state and local public health agencies and their MCH programs, of the state's changing demographics include:

- An increase in the median age from 32.5 to 41.3 between 1990 and 2025. Projections include substantial growth in the 45-64 population, significant growth in elderly age groups and a slight drop in the child population 0-14.

- There is a projected substantial increase in all populations of color between 1990 and 2020. Most non-white racial groups will make up a larger percentage of youth 14 and under than they will of other age-cohorts. For example, state demographer projections for the year 2005 estimate that 14.2 percent of youth 14 and under will come from non-white racial groups compared to 8.9 percent of the total population and 3.1 percent of those 65 and older. The percent of minority students enrolled in public K-12 during the 1988-89 school year was 8.6 percent of all students; a decade later during the 1998-99 school year this percent had risen to 15.2 and in the 2001-2002 school year 18 percent were students from minority or racial populations.

- International migration added approximately 7,000 individuals to the state's population each year from 1990 through 1998. In 1998, immigrants from at least 90 different countries settled in Minnesota (the 2000 census data tract for immigrants is not yet available). Not only are the numbers of immigrants substantial, but the percentage of immigrants who are refugees compared to the U.S. total is quite high.

- There was a three-fold increase between 1990 and 1999 (from 20,231 to 55,888) of the number of school children living in households where a language other than English was spoken (Minnesota Planning, B.J. Ronningen, email communication, February 25, 2000). At least 67 different languages are spoken in these students' homes (Ronningen).

2. Poverty Timely, accurate and meaningful data on poverty, especially for children, are difficult to obtain. According to estimates from the federal census bureau, the number of Minnesota children under 18 years of age living in poverty during 1995 was estimated at 11.7 percent and the number of children under 5 living in poverty was estimated at 13.0 percent. /2004/ In 1999, 9.2 percent of children under 18 years were living in poverty. //2004//.

MinnesotaCare is the state's subsidized health insurance program that is administered by the Minnesota Department of Human Services. For state fiscal year 1997, children represented almost 55 percent of all enrollees (99,555), with 91 percent of these children were from families whose income level was 200 percent or less of the federal poverty guideline (FPG) and 71 percent of the children were from families whose income was at or less than 150 percent FPG.

A more direct measure of childhood poverty in Minnesota is the level of participation of public school students in the state's K-12 free and reduced school lunch program. Free school lunches are available to children in families whose income is at or less than 130 percent of the FPL and reduced-price school lunches are available to children in families whose income is at or less than 185 percent of the FPL. The number of children enrolled for free school lunches have raised from 17.4 percent of public K-12 students in the 1991-92 school year to 18.3 percent in the 2000-01 school year. The number of students enrolled for reduced-price school lunch rose from 5.9 percent of the public K-12 population in the 1991-92 school year to 7.5 percent in the 2000-01 school year. In the Minneapolis and the St. Paul school districts, the number of K-12 students eligible for the free school lunch

program ranges from 66 to 63.5 percent respectively in 2001.

3. Urban/Rural Contrasts Rural Minnesota is characterized by, low population density, a greater proportion of the elderly and lower income levels. These differences become further complicated by factors such as geography, transportation, the state's size and its climate.

The Minnesota Planning Agency estimates 28 percent of Minnesotans live in rural areas. Rural population is defined as the population not living in an urbanized area or in cities of 2,500 or more located outside of an urbanized area.

In a recently released report on health insurance in Minnesota, the report's authors divided the state into three parts: Minnesota counties of the Minneapolis-St. Paul MSA (Twin Cities Metro), all other Minnesota counties in a MSA (other Metro), and the remaining non-MSA counties (non-Metro). The study concludes that larger portions of the population in rural counties are covered by Medicare; (15.0 percent in non-metro versus 11.8 percent in other metro counties and 10.5 percent in Twin Cities Metro counties). This greater percentage of the population that is covered by Medicare means that rural health care providers are more dependent on Medicare revenues than their colleagues in metro areas. This pattern also appears to hold for other publicly funded programs such as the state's Medicaid program and its MinnesotaCare program.

4. Disparities in Health Indicators Although Minnesota rank favorably on most health measures it has significant disparities in health status and health outcomes among various population groups:

- Rankings by private sector insurance interests consistently rate state residents as among the healthiest in the nation. Yet people of color in the state are at greater risk of heart disease, cancer, stroke, diabetes, homicides, suicides, and unintentional injuries.

- The life expectancy of its residents is the second best in the nation. Yet the self-reported suicide (ever) attempt rate among its 12th grade male youth is 9 percent and among its 12th grade female youth is 15 percent.

- Median household income in 1997 dollars of \$41,482 (1995-7 average) is the seventh highest in the nation. Yet 8.7 percent of its total population and 13.0 percent of its children under 5 live below the poverty level.

- Overall infant mortality rates are consistently well below the national average. Yet the average rates for African Americans and American Indians are three times as high as other racial and ethnic groups in the state.

- The percentage of low-birthweight newborns is also consistently among the lowest in the nation. Yet large disparities exist with percentage of singleton births under 2,500 grams between African-American newborns and other racial and ethnic groups.

- Pregnancy rates among 15-17 year-olds are decreasing. Yet the rates for Native-American teens and African-American teens remain 3 to 4.5 times higher, respectively, than the overall average.

/2003/ American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

American Indians and Alaska Natives living in Minnesota fall short of the overall population on indicators of both economic and health status. A recent report by the Children's Defense Fund-Minnesota (2002) revealed that 67% of American Indian children lived below 185% of federal poverty guidelines. In addition to experiencing greater degrees of poverty than was true of the overall population, American Indians experienced diminished levels of health according to the report. For example, American Indian teens gave birth at a rate that was 5.5 times greater than for White teens (62 versus 11/1000). And, infant death rates among American Indians were approximately 2.5 times greater than for Whites (14 versus 5.5/1000). These findings give rise to concern and are the basis for interventions discussed in other sections of this application.

## B. Health Care Delivery Environment

1. Financial Access: The state continues to maintain one of the lowest rates of uninsured populations in the nation; and unlike the rest of the country, the state's uninsured rate has remained significantly unchanged since 1990 although the profile of its uninsured has changed since then.

Estimates of the number of uninsured people in the state vary according to specific data sources, ranging from 5.2 percent to slightly more than 9 percent. Minnesota-specific studies conducted in 1990, 1995 and 1999 indicate the uninsured rate was 6.0 percent in both 1990 and 1995 and 5.2 percent in 1999. National data from sources such as the Current Population Survey (CPS) estimate the uninsured rate at the higher level of 9 percent. Analysis of the 1999 study by the Minnesota Department of Health reveals that children 17 and under made up a smaller proportion of the uninsured in 1999 than they did in 1990 or 1995 (16.5 vs. 25.0 and 18.2 percent, respectively). This pattern holds true when children's age cohorts are divided into birth through five years and six through seventeen. In addition, the overall rate of uninsured children declined from 5.3 percent in 1990 to 3.4 percent in 1999. An important trend observed from the state-specific studies is a decline in the proportion of long-term uninsured who are children. In 1990 almost 29 percent of the long-term uninsured (defined as being without insurance for 12 months or longer) were children under the age of 18; by 1999 this percentage had fallen to 14.6 percent. While the percentage of children who lacked health insurance for twelve months or more decreased during this time frame, the proportion of children who were uninsured for part of a year remained unchanged. (1995 at 26 percent but declined to 22 percent in 1999).

According to 1997 data compiled by the Department of Health, two-thirds to 70 percent of the state's population had private sector health insurance and approximately 25 percent of the state's residents had insurance either through Medicare (14% ) or through one of the state's three publicly funded programs (Medical Assistance [8%], MinnesotaCare [2%], and General Assistance Medical Care [1%]). The remainder of the population was uninsured. Self-insured plans cover 29 to 32 percent of all state residents or about 43 percent of those Minnesotans with private health insurance.

The 2001 Minnesota Health Access Survey found that 6.4% of children living in the state were uninsured (Minnesota Department of Health, 2002).

2. State Funded Programs Minnesota provided health insurance coverage for 691,000 state residents at some point during state fiscal year 2001 [unduplicated number ever enrolled in MA, GAMC or MinnesotaCare during FY 2001]. /2004/ Changes made during the 2003 Minnesota Legislative session will impact the number of individuals eligible and enrolled on Minnesota's public programs.//2004//

Medical Assistance (MA). Medical Assistance is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. Families, children and pregnant women account for 68 percent of Minnesota's MA enrollees and 22 percent of its expenditures. Program expenditures for state fiscal year 2001 totaled \$3.5 billion, of which the federal share was \$1.8 billion. Enrollment as of December, 2001 was estimated at 395,000 including 215,000 children under 21. Comparable figures for December, 2000 were 372,000 including 202,000 children under 21; and for December, 1999 were 363,000 and 198,000 respectively (Minnesota Department of Human Services, G. Hoffman e-mail communication, June 11, 2002).

The state currently operates its Medicaid program with five Section 1915(c) home and community-based waivers, one Section 1915(b) freedom of choice waiver, and three Section 1115 waivers. Section 1115 waivers include: 1) a waiver to permit implementation of performance based contracting for ICF/MR services, 2) the Minnesota Senior Health Options waiver and 3) the state's waiver for its Prepaid Medical Assistance Program (PMAP) as it was originally called or the MinnesotaCare Health Care Reform Waiver (or PMAP+) as it is now called. /2003/The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915(b) freedom of choice waiver, six Section

1915(c) home and community based waivers, and one Section 1115 waiver. The Section 1115 waiver is the state's waiver for its MinnesotaCare Health Care Reform Waiver (PMAP+). Another Section 1115 waiver, which permitted implementation of performance based contracting for ICF/MR services, expired in September 2000 and a third, the Minnesota Senior Health Options (MSHO) waiver, has been converted to Section 1915(a) for the Medical Assistance aspect of the project.

The most important Medicaid 1115 waiver is the state's PMAP+ waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Medicaid populations initially covered by the PMAP program included families with children, elderly, and persons with chronic illness or physical disabilities (including blindness). The state disenrolled from PMAP the blind and disabled populations in late 1987 because of policy and operational issues.

Changes that occurred over time included: expansion of the program statewide, simplification of some MA eligibility requirements, federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section), and expansion of PMAP covered populations to include a) children eligible for MA under TEFRA to coincide with enrollment of persons with disabilities into managed care, b) children in foster care placement, c) children eligible for MA through subsidized adoptions, and d) on a voluntary basis, children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management. As of December 1999, 58 of Minnesota's 87 counties were participating in the PMAP+ program and the remaining counties were awaiting federal (1115) approval for a form of managed care called county-based purchasing. A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 approval. /2004/ The 2003 Legislative changes in response to the state's large budget deficit will have a significant impact on mothers, children and children with special health care needs. Beginning July 1, 2004, income eligibility for pregnant women will go from 275 percent of FPL to 200 percent of FPL. Income eligibility for children under age 18 will be lowered from 170 percent of FPL to 150 percent of FPL. Beginning July 1, 2003, parental fees for children on the TEFRA waiver program were increased by more than 1,000 percent in some cases, waiver slots for MR/RC, TBI, CADI were reduced or capped, and services to adults were modified, requiring co-pays for drugs, doctor visits and emergency room visits while dental care is limited to \$500 per year. //2004// ***/2005/ Preliminary approval for this 1115 waiver demonstration project has been received. Some changes were made that would reduce the eligibility limit to 200% FPG and make the automatic MA family planning coverage to anyone who loses MA or MinnesotaCare to 12 rather than 24 months. MCH staff will continue to work with DHS staff to plan for 2006 implementation. //2005//***

MinnesotaCare. Minnesota began its health care reform activities in 1988 with authorization of the Children's Health Plan (CHP). CHP was a state subsidized insurance plan that provided coverage for outpatient health services to children over the age of one and under the age of 9 who were ineligible for Medical Assistance or GAMC and whose family income did not exceed 185 percent of the FPG. The upper age limit was subsequently extended to 17. In 1992, the state began to intensify reform activities when it passed its first major health care reform legislation now known as MinnesotaCare.

Building upon the principles of the CHP, the 1992 legislation authorized, among many other reforms, a subsidized health insurance program for adults as well as children and also expanded coverage to include inpatient hospital services. MinnesotaCare is a state subsidized program funded by state taxes, enrollee premiums and enrollee co-payments. It was initiated in October of 1992 and as of December, 1999 had an enrollment of 112,088 of whom 57,075 were children. Families with children are eligible for the program on a sliding-fee scale if their family income is less than 275 percent of the FPG. Currently, single adults and adult families without children are eligible on a sliding-fee basis at up to 175 percent of FPG. Other eligibility criteria also apply. The entire program was converted to managed care in the latter half of 1996. Federal financial participation is claimed for pregnant women

and for children and benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program.

/2003/It was initiated in October of 1992 and as of December, 2001 had an enrollment of 142,000 of whom 68,000 were under 21.

Erosion or crowd-out barriers consist of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) in the 18 month period prior to enrollment in the MinnesotaCare program. /2004/ In response to the state's budget deficit, a more limited benefit set was established for adults without children. Benefits limited to hospitalization, physicians, drugs, outpatient services and lab/diagnostic services. A \$10,000 limit on hospital care with a 10 percent co-pay requirement was added. In addition premiums were increased for all populations using the program.//2004//

General Assistance Medical Care (GAMC) GAMC is a state and locally funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. Individuals who may be eligible include non-citizen children, persons who are incapacitated or of advanced age, undocumented and nonimmigrant persons. /2003/Program enrollment as of April 2002 was 33, 883 including 1,599 children. The program provides coverage for the same health services offered by the MA program except for long-term care, home care or personal care services. /2004/ As part of the state's response to the budget deficit, eligibility for GAMC was lowered from 175 percent of FPL to 75 percent of FPL. A new "catastrophic" health program for individuals between 75 percent of FPL and 175 percent of FPL was established but, to cover hospitalization costs only and includes a \$1,000 deductible.//2004//

Childrens' Health Insurance Program (CHIP) or Title XXI In September of 1997 the Minnesota Department of Human Services convened a statewide stakeholders group to begin discussion of a Title XXI plan. This discussion ultimately resulted in legislation signed by the governor on April 9, 1998. This law directed the Department of Human Services to request Title XXI funding for the following three areas:

1. Expansion of the Medical Assistance income standard for children under age two from 275 percent to 280 percent of Federal Poverty Guidelines;
2. Expenditures for children enrolled in MinnesotaCare, and other services and administrative activities that may be eligible for enhanced funding which would require Title XXI waivers.
3. A proposal to subsidize employer-based insurance for children of employees who are ineligible for MinnesotaCare due to the availability of employer-subsidized insurance.

The expansion of the income standard for children under the age of two to 280 percent of poverty guidelines was approved by the U.S. Department of Health and Human Services as a Medicaid expansion under Title XXI in July of 1998. The state's request for waivers from Title XXI requirements to enhance matching funds for children enrolled in MinnesotaCare and for other health initiatives was denied. /2003/An S-CHIP-funded Medicaid expansion of the income standard for children under the age of two to 280 percent of poverty guidelines was approved in July 1998. Beginning in July 2001, the state began claiming S-CHIP match for certain parents enrolled in MinnesotaCare. /2004/ Beginning with state fiscal year 2002, state funding supporting family planning services for adolescents and MCSHN Treatment program expenditures was approved to draw down S-CHIP funds. //2004//

3. Private Sector Trends/Managed Care The vast majority of health care delivered in Minnesota occurs within the private sector and through managed care plans. About 60 percent of Minnesotans

were enrolled in some type of managed care plan in 1990 and by 1995 this had increased to 80 percent. Between 1993 and 1997, the enrollment rate in HMOs of employed Minnesotans increased from 25 to 31 percent, enrollment in preferred provider organization/point of service arrangements increased from 38 to 59 percent and enrollment in indemnity plans decreased from 37 to 10 percent.

The state estimates that HMOs enroll about 50 percent of the state's population that is covered either through contracts with self-insured employers or through contracts for fully-insured (commercial) plans. This would translate to approximately one-third of the entire population and does not include populations served by other managed care types of delivery such as PPOs. The revenue streams of licensed HMOs have been under substantial stress in the last four years because of intense premium and market share competition in the commercial HMO area.

Consequently, premiums have increased accordingly. While no systematic data exists, data on state employee group health premium costs indicate a 6.7 percent increase in 1997 and a 10.1 percent increase in 1998. Commercial premiums rose by 8.1 percent in 1998 for the state's HMOs. Increases in 1999 for the small group market range from 9 to 28 percent for the HMOs.

Although most plans have experienced a loss on their fully-insured and Medicare-risk products in the last few years, they have had a net profit because of earnings from investments and profits earned on Medicaid managed care plans (PMAP+).

In addition, the impact of the provisions that both the Balanced Budget Act of 1997 and the BBA Refinement Act of 1999 (P.L. 106-113) will have on Medicare managed care and the concept of direct contracting for Medicare enrollees is not completely understood in the state. The impact of many of the changes due to the BBA of 1997 in Medicare, Medicaid and S-CHIP, and now the 1999 BBA, and the interrelationships among one another of those changes are only beginning to have their presence felt in the state's marketplace.

There is a private sector direct contracting initiative being undertaken in the Minneapolis/St. Paul metropolitan area by the Buyers Health Care Action Group (BHCAG). This group is a coalition of 26 self-insured employers that helped to support a number of reforms in the early 1990's, including the concept of vertical integration between insurers and providers. By 1995-96, however, it had become concerned about the magnitude of the consolidation of health plans, insurers, hospital and physician systems that had occurred in the state and, in particular, the Twin Cities. As a result, BHCAG signaled its intent to contract directly with small groups of providers on behalf of its members' employees and their dependents in a manner that it believes will not jeopardize the employers' self-insurance status.

/2003/Premium and Cost Trends in Minnesota : After leveling off in the mid-1990s, health insurance premiums in Minnesota and the nation have been rising at or near double-digit levels since about 1998. This trend has led to concerns that some Minnesotans might lose their health coverage, as the result of employers dropping health benefits, employers passing on increased costs to employees, and/or employees' share of health insurance premiums becoming unaffordable.

In the private market, health insurance premiums per person rose by about 16.1 percent in 2000, following increases of 12.1 percent in 1999 and 8.9 percent in 1998; in contrast, premiums grew by 1 percent or less each year from 1995 through 1997. Similar to what has happened in Minnesota, premium increases nationally were very low in the mid-1990s, but have begun to rise more quickly in recent years.

It is difficult to tell what impact the rapid health insurance premium increases of the last few years has had on private health insurance coverage in Minnesota. There is some anecdotal evidence that faced with a strong economy and low unemployment; employers were reluctant either to drop coverage or to pass premium increases on to employees. However, some observers are concerned about the potential impact of an economic slowdown and rising unemployment.

The current rapid growth in health insurance premiums comes at a time when consumers are

increasingly resistant to health plans that are tightly managed to control costs. This factor makes it difficult for employers to institute new cost control measures in response to premium increases. In fact, the trend in the past few years has been toward less restrictive plans, which is likely part of the reason why underlying costs are now rising more quickly than they did during the mid-1990s. Anecdotal evidence and reports of employer reactions to premium increases in other parts of the country suggest that employers may be more likely to institute changes in benefits such as higher co-payments and deductibles than to move toward more tightly managed care.

#### C. Title V Program Role

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for programs and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. However, as explained in the previous section the need for it to directly engage in safety-net medical services delivery is limited.

The Division of Family Health in the Minnesota Department of Health (MDH) administers, coordinates and supports many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards, the Minnesota Department of Education; Economic Security; Corrections; and Public Safety.

#### D. Current Departmental Priorities/Initiatives - Title V Program Involvement

As the Minnesota Department of Health positions itself for the next years of this decade, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Jesse Ventura, has directed that a four-part initiative be undertaken throughout all levels of state government called "The Big Plan". Its four components include building healthy, vital communities; self-sufficiency of state residents; state government dedicated to service; and a state that is competitive in the world's marketplace. Within the many sub-initiatives of these four components is one on health system reform focused on producing better health status for all Minnesotans. /2004/ Tim Pawlenty was elected Governor in November and took office in January 2003. //2004// **/2005/Governor Pawlenty has made prevention a priority for his administration, with a specific interest in obesity. //2005//**

In 1999 the Department adopted a set of strategic directions (MDH Strategic Directions) on issues it felt to be crucial to ensure a vital and healthy Minnesota. These issues include elimination of disparities in health status, improvement of the readiness of the department's response to emerging health threats, reduction of tobacco use and improvement of the health of Minnesota's youth, bringing the community together on state public health goals and preparing the state for the next wave of health care reform. /2004/These strategic directions will be reviewed this summer to determine current priorities. //2004// **/2005/ The MDH Health Steering Team (HST), made up of the Executive Office staff and Division Directors, has undertaken strategic planning activities which led to the development of work groups to look at these priorities: 1. Vision for MDH; 2. Organizational Structure; 3. Regulatory Roles, Responsibilities and Process; 4. Defining a Coordinated Process for Pursuing Funding for MDH Priorities; 5. Interagency Initiatives; 6. Providing Optimal Support to Local Agencies Responsible for Public Health; and 7. Data Collection. //2005//**

Throughout 1998 the Department undertook an effort to revise the state's public health goals and

objectives. Following development of the public health goals and objectives, the Department Published Strategies for Public Health which is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of Healthy Minnesotans, 2004. /2004/Title V staff are currently updating the Goals and Strategies impacting maternal and child health populations. //2004//

Minnesota consistently scores high on rankings of state's measures of health status. However, as noted previously this status is not equally shared among its racial and ethnic populations and very large disparities exist in indicators of infant mortality and teen pregnancy. In 1999 Title V program staff, in partnership with the Department's Office of Minority Health, developed an application to the Centers for Disease Control and Prevention (CDC) for a REACH (Racial and Ethnic Approaches to Community Health) demonstration grant. During 1999-2000 the grant supported community-based planning process which developed a comprehensive action plan for systems change related to reduction of infant mortality in the African-American and American-Indian communities residing in Hennepin (Minneapolis) and Ramsey (St. Paul) Counties. The initial application for CDC continuation funding was not approved, but a reapplication was submitted in June, 2001. In addition, the Title V program co-sponsored a symposium in mid-1999 to address the adolescent pregnancy rate among African-American adolescents, which is among the nations highest and has subsequently supported follow-up activities by the Office of Minority Health. /2003/ The June 2001 reapplication to CDC for implementation grant funding of the REACH project was not approved, but the process and outcome of the planning phase contributed to the development of the successful Eliminating Health Disparities Initiative which was enacted.//2003//

A significant number of new Governor's initiatives related to maternal and child health were proposed for consideration by the 2001 session of the Minnesota Legislature. Title V staff were actively involved in development of the initiatives, in follow up activities to assist their consideration during the session and implementation after session. A summary of the most significant proposals and their outcomes follows:

**Teen Pregnancy Prevention:** This legislative initiative proposed to provide \$10 million in TANF (welfare reform) funds for a comprehensive, multi-faceted and community-based approach to teen pregnancy prevention. The initiative was not enacted. However, \$9 million was made available for related components in other existing programs (Youth Risk Behavior Program, Family Home Visiting Program , MN ENABL, and Eliminating Health Disparities Initiative).

**Eliminating Health Disparities :** This legislative initiative proposed to provide funding to communities to work on meeting the Nation's health disparities objectives for 2010, in one or more of the following areas: Infant Mortality; Breast and Cervical Cancer Screening; Cardiovascular Disease Prevention; Diabetes; Violence and Injury Prevention; Immunizations; and HIV/AIDS/STDs. The initiative was enacted. The process for distribution of new Health Disparities funding to community agencies was based upon community input and the extensive involvement of community representatives in the application review process.

**Healthy Kids Learn:** To meet the challenge of an optimal learning environment, children need first to have their health concerns addressed, and they also need to have a safe and healthy school environment. This initiative proposed to meet this challenge through the creation of a Healthy Kids Learn Endowment, using funds from the State's Tobacco Settlement Fund. The initiative was not enacted

**1115 Medicaid Waiver for Expanded Family Planning:** This initiative proposed development of a Medicaid waiver request to permit the Minnesota to provide two years of automatic MA family planning coverage to anyone who loses MA or MinnesotaCare and to individuals with income at or below 275% of the federal poverty level. The initiative was enacted. ***/2005/ Preliminary approval for this 1115 waiver demonstration project has been received. Some changes were made that would reduce the eligibility limit to 200% FPG and make the automatic MA family planning coverage to anyone who loses MA or MinnesotaCare to 12 rather than 24 months. MCH staff***

***will continue to work with DHS staff to plan for 2006 implementation. //2005//***

#### E. Decision-Making Process In Face Of Competing Factors

There are a number of institutionalized forums that allow the Commissioner of Health, and the Family Health Division director to remain up-to-date on the social, political and economic dynamics affecting health care issues. Some of them are described more extensively under D. Coordination with Other Governmental Agencies, and in other sections of the application. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues, which affords the Title V Directors a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. Health Steering Team (HST): The HST consists of the health department's Executive Office staff and the Division Directors. It meets every two weeks to provide input into departmental policies, determine priorities, and to identify and resolve issues.
2. State Community Health Services Advisory Committee (SCHSAC): The SCHSAC is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. In addition, each year the SCHSAC forms 3-5 work groups comprise of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals.
3. Maternal and Child Health Advisory Task Force (MCHATF): The MCHATF is another standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15 member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. It too, forms work groups to address issues or topics that are of particular concern. ***//2005/ The MCHATF created two priority work groups this year to focus on: 1. monitoring the impact of the 2003-2004 Legislative Session policy and budget changes, and 2. maintaining and improving early childhood programming. The work of both groups is actively underway. The Task Force is also committed to active participation in the 2005 MCH Needs Assessment. //2005//***
4. Rural Health Advisory Committee: This health department advisory committee consists of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It too carries out its responsibilities through work groups. ***//2005/Current focus is on mental health issues in rural communities. //2005//***
5. Minnesota Health Improvement Partnership (MHIP): The MHIP is a broad coalition of statewide health care organizations including health plans, professional associations, and consumer advocacy organizations. It was formed to advise the Commissioner and Department of Health on activities that could advance the vision of health as a shared responsibility and to develop coordinated public, private and non-profit efforts to improve the health of Minnesota residents. As a part of its workplan, an Adolescent Health Services Action Team met to review current state and national recommendations and reports regarding the delivery and financing of health services for adolescents, assess the extent to which the recommendations have been implemented in Minnesota and identify barriers to implementation, and make recommendations to assure a solid continuum of clinical and community based health services for this population. *//2003/ MHIP staff have conducted an assessment of the activities of participating organizations to identify the ways that they are using the document's recommendations in their work.*
6. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet quarterly to discuss maternal and child health issues and proposed changes in their respective

programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency.

7. Division Management: The Division Managers and the Section Managers of the Division of Family Health meet on at least a monthly basis to resolve immediate operational issues and to discuss and define long-range issues.

## **B. AGENCY CAPACITY**

A description of organizational structure (A. Director's Office: Director's Office has a total of 14.85 FTEs funded by State appropriations [7.85 FTE]; MCH Block Grant [3.70 FTE]; Preventive Block Grant [1.0 FTE]; HRSA [1.0 FTE] and WIC [1.3 FTE]. The Division of Family Health has a broad and diverse focus of responsibilities and activities which it undertakes to improve the health of Minnesota's individuals, families and communities. The Director's Office is responsible for overall management, administration, and direction of the Division. Included in this are activities of policy and program planning, development, evaluation, and coordination. Additional responsibilities include the implementation of new initiatives such as the Woman's Right to Know Act ***/2005/ and strengthening the mental health component of emergency preparedness activities. //2005//***

The Division Director is an occupational therapist by initial training. She completed a Master of Science in Public Health degree in 1997 and has had many years of experience in maternal and child health program administration and planning; policy development and analysis; and interagency collaboration. The attached file contains her biographical sketch. The Director's Office staff include:

Dental Health: The Dental Health Program provides oral health promotion training, technical consultation, and assistance to professionals and educational materials to Community Health Boards, schools and the general public. Program staff partners with the Department of Human Services in areas of dental policy and access issues. */2003/*Oral health is essential to overall health and well-being and is not solely dependent on individual behaviors. The dental program works with; 1) water engineers and other individuals sharing community fluoridation responsibilities; 2) school and community leaders to expand and enhance school-based or school-linked dental sealant programs and oral health information and services linkages; 3) oral health advocacy groups to establish statewide oral health monitoring systems and oral health research projects; 4) oral health care providers to address the significant issues surrounding dental access; and 5) medical primary care providers to boost attention to the significance of oral health and overall well-being. ***/2005/New federal funding has allowed the Dental Health Program to strengthen the focus on improving oral health of young children and pregnant mothers. Through partnerships with WIC clinics and the state's EPSDT Program, dental screening protocols and anticipatory guidance activities are being implemented. //2005//***

Suicide Prevention: A Project Consultant Senior position was created in the Director's Office in 1999 in response to the 1999 Minnesota Legislature's direction that the Minnesota Department of Health (MDH) conduct a study of suicide in Minnesota and, in consultation with a large group of stakeholders, develop a statewide suicide prevention plan. MDH submitted the Suicide Prevention Plan to the Legislature on January 15, 2000. Based upon this work the governor proposed for the next biennium an appropriation to strengthen the capacity of state and local public health agencies to work with communities to address suicide prevention. Funding of \$1,100,000 per year was appropriated. */2003/* In 2002, for the first time the Preventive block grant funded activities in mental health, promoting the National Health Objective: 18 1. Reduce the Suicide Rate. Strategies include providing direction and capacity building for MDH, state, and community mental health promotion and suicide prevention program planning and implementation, with special emphasis on reducing health disparities. Through these activities, the Mental Health Program will address the mental health and suicide prevention information and education needs of key MDH staff, Community Health Boards, health providers and other community members. */2004/* The 2003 Minnesota Legislature reduced the

suicide prevention competitive grants funds by \$123,000 per year. Also in 2003, a new program component was added to address planning for mental health and emergency preparedness. Specific planning activities are included in the CDC and HRSA bioterrorism grants//2004//

**Youth Risk Behavior:** The Youth Risk Behavior Endowment is a new Minnesota Department of Health initiative that is giving local public health agencies an opportunity to address a broad range of youth risk behaviors and the risk and protective factors that influence these behaviors. The targeted risk behaviors include alcohol and other drug use; sexual behaviors that may result in pregnancy, HIV and STDs; violence; suicide; physical inactivity; and unhealthy dietary behaviors. Funding for this initiative is provided through the Tobacco Prevention and Local Public Health Endowment established during the 1999 legislative session. Funding is provided to all Community Health Service agencies through non-competitive grants. Funding in sfy 2001 was \$2.0 million growing to approximately \$5 million in 2003. /2003/ An additional \$1 million a year in funding was appropriated. Total funding for state fiscal year 2002 is \$3.4 million (Endowment funds) and \$950,000 (TANF funds). /2004/In response to the budget deficit the 2003 Legislature redirected TANF funding to other programs and funding established through the Tobacco Prevention and Local Public Health Endowment was discontinued and the principal of the tobacco endowment was transferred to the General Fund. While funding for grants were eliminated, youth risk behavior efforts continue to be a high priority and technical assistance to local public health continue. //2004//

**MCH Advisory Task Force:** The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH Professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. The Task Force is staffed out of the Director's Office, and appropriate consultant staff of the division's sections staffs Task Force projects. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. /2004/ Under the redesigned Local Public Health Grant passed in the 2003 session, the Task Force will be developing state-wide maternal and child health outcomes for Community Health Boards. These outcomes will begin January 1, 2005 and will be revised every 5 years. //2004// **/2005/ The MCH Advisory Task Force's current work plan includes 1) participating in the 2005 Needs Assessment; 2) monitoring the impact of the 2003-2004 legislative session policy and budget changes on mothers and children; and 3) improving early childhood programming. //2005//**

**Coordinated School Health Project :** The Centers for Disease Control and Prevention, Division of Adolescent and School Health (DASH) is funding initiatives in twenty one states that are designed to build a coordinated education and health agency infrastructure to support coordinated school health programs and to strengthen comprehensive school health education to prevent important health-risk behaviors and health problems. Minnesota is one of the states funded for this initiative and received its initial grant in late 1995. The cooperative agreement facilitated the creation of a partnership between the Minnesota Department of Children, Families, and Learning and the Minnesota Department of Health. The Coordinated School Health Program (CSHP) is defined as a planned and comprehensive school-based program designed to enhance child and adolescent health. It is made up of eight components including healthful school environment; health services; health education; physical education; counseling, psychological and social services; nutrition services; parent/community involvement; and health promotion for staff. The primary premise is a model that involves all aspects in a planned and comprehensive CSHP that will eliminate program gaps and overlap, provide more effective programming, and improve the school's ability to enhance the health of children and adolescents. /2004/ CDC funding for this initiative will end in November 2003. //2004//

**/2004/Administrative Activities:** The responsibility of this unit is to provide the support necessary for the Division to do its work. Centralized administrative, computer, financial and grants management supports allow for Division efficiencies. //2004//

B. Maternal and Child Health Section: The Maternal and Child Health Section has a total of 36.6 FTEs funded by State appropriations [12.7 FTE]; MCH Block Grant [12.20 FTE]; Medicaid [ 2.55 FTE]; CDC and HRSA Newborn Hearing Screening Grants [2.55]; HRSA Woman's Health Grant [1.0 FTE]; Title X [.30 FTE]; CDC FAS Grant [2.50 FTE]; Early Childhood Grant [1.0]; and HRSA Genetics [1.80 FTE]. The Maternal and Child Health Section is organized into the Section Manager's office and four units: Reproductive Health, Child and Adolescent Health Screening/Health Promotion, Child and Adolescent Health Policy & Support Unit. All but two persons are based in the St. Paul Central Office. The Section Manager is a board eligible public health physician with over 25 years experience in maternal and child health administration. Other staff within the office includes the staff responsible for fiscal management of the Section and data activities including the Title V performance measures development and reporting and program evaluation. This is also the focus of the "Reaching to Eliminate Health Disparities in Minnesota" Project. This Project, funded by the federal Centers for Disease Control and Prevention, targets the African American and American Indian population of Hennepin and Ramsey Counties and seeks to eliminate infant mortality disparities by 2010. //2003/The June 2001 reapplication to CDC for implementation funding of the REACH project was not approved, but the process and outcome of the planning phase contributed to development of the Governor's Eliminating Health Disparities Initiative which has enacted. //2004/ After thirty years, the MCH Section Manager retired in 2003. The Division Director is currently interviewing candidates and it is anticipated that the position will be filled by early this fall. //2004// **//2005/ Organizational changes for the Family Health Division were implemented that impacted the structure of the MCH Section. There are four units in the Section: Newborn and Child Screening, Perinatal Health, Women's & Reproductive Health, and the Support Unit. A new Section Manager was hired in February and has worked at local and state public health agencies in family health programs for 25 years. Program supervision and management experiences have included WIC, Child and Teen Check Ups, Home Visiting for high risk parents, Family Planning, and Disease Prevention and Control. The Section Manager also has considerable experience working in multi-sector collaborative efforts. //2005//**

The Maternal and Child Health program strives to improve the health status of children and youth, women and their families. The MCH Section provides a focal point for influencing the efforts of a broad range of agencies and programs committed to this goal. The Section supports their efforts by providing administrative and program assistance to Community Health Boards, Tribal Governments, schools, voluntary organizations, children's mental health and family collaborative, and private health care providers.

In addition to its technical support efforts, the program is also responsible for administering the state-funded Family Planning Special Projects and MN ENABL (Education Now and Babies Later) grant programs, the Maternal and Child Health Special Projects grant program funded by federal Title V funds supplemented by state general funds, the Abstinence Education grants and contracts (Section 510), contracts for Maternal Death Studies (state), Sudden Infant Death Syndrome services (Title V), Home Visiting Program to Prevent Child Abuse and Neglect grants and contracts (state), and Minnesota Healthy Beginnings (MHB) grants and contracts (state) and Public Health Nursing Home Visiting (TANF).

The primary functions of the activity have been quality assurance of public sector health services, assurance of targeted outreach and service coordination for hard-to-reach and high-risk populations, and community health promotion. Increasingly attention is being directed to assessment of health problems and policy development and planning. MCH Section staff, by unit are as follows:

Reproductive Health Unit: The Reproductive Health program unit works with health providers to develop quality preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. This unit assesses needs, develops standards, and provides technical support services, training and public education. It administers the Family Planning Special Projects, MN ENABL, and Abstinence Education grants programs. The component also assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to

physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The unit also includes the Infant Mortality Reduction Initiative (IMRI) and Women's Health coordination. The Women's Health coordination provides opportunity for the women's health programs of the Department to work together so that systems of care serving women are improved. /2003/Effective in CY 2003 the MN ENABL and Abstinence Education funding and identity will be merged into the MN ENABL program. Primary prevention aspects of the FAS Program were relocated from the Center for Health Promotion into the Reproductive Health Unit of the MCH Section. /2004/ In addition to the above programs, the unit administers Title X grant and the Women's Health Grant programs. Women's Health Grant activities are focused on increasing the number of low-income women of color receiving primary and preventive health care services by identifying service gaps and eliminating barriers to care. //2004// **/2005/ As a result of structural changes this unit was named Women's and Reproductive Health. It administers the Family Planning Special Projects, Title X, MN ENABL (Education Now and Babies Later), and the Woman's Health Grant. Infant Mortality and Fetal Alcohol prevention activities were moved to Perinatal Health. Administration of the State Early Childhood Comprehensive System of Care (SECCS) grant is temporarily in the unit while work is completed on construction of a Child Health Unit. The goal of this grant is to develop a state plan for an integrated and comprehensive early childhood system. //2005//**

Child and Adolescent Health Screening/Health Promotion Unit: The Child and Adolescent Health Screening/Health Promotion program unit supports accessible high quality health and developmental screening and health promotion for all children in the state. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation and training under contract with the Department of Human Services, Denver Developmental Screening Test II trainings, Nursing Child Assessment Satellite Training (NCAST) program, the scoliosis screening program, and maternal/infant mental health.

The voluntary universal newborn hearing screening (UNHS) program received funding from HRSA/MCHB for the period April 1, 2000 to March 30, 2004. The funding will support expansion of UNHS activities especially in the areas of technical assistance to hospitals, early intervention and follow-up, provider training, public information and enhancement of a statewide family-to-family support network. Program activities will be coordinated with Part C Program along with other MDH staff, faculty from the University of Minnesota Department of Otolaryngology, and members of the UNHS Advisory Committee. Additional funding to develop an early hearing detection and intervention (EHDI) tracking and surveillance system was received from Center for Disease Control and Prevention (CDC) from October 1, 2000 to September 30, 2005. The early hearing detection and intervention (EHDI) tracking and surveillance system is obtaining newborn hearing screening results through expansion of the metabolic (blood spot) form with a goal of future integration with vital statistics (birth certificates) via a web-based system.

The unit also includes three home visiting grant programs. The Home Visiting Program to Prevent Child Abuse and Neglect, originally established in 1992, is a public health nursing program that provides intensive, long-term home visitation services targeted to families with identified risk factors. The purpose of this program is to prevent child maltreatment and to promote positive parenting practices. Minnesota Healthy Beginnings (MHB), established in 1997, is a universally-offered program that provides less intensive home visitation to all families with newborns, irrespective of income or risk. The purpose of the MHB program is to strengthen families and to promote positive parenting and healthy infant development. The Temporary Aid to Needy Families (TANF) public health nurse home visiting program is the third program, enacted in 2000. Twenty-one million dollars is allocated to local public health agencies over 3 years. The program provide home visiting services to families at or below 200 percent of the federal poverty level. A Family Home Visiting Work Group is developing recommendations for the integration of these home visiting programs and the recently expired home visiting Program to Prevent Child Abuse and Neglect. Members of the work group include

representation from health plans, local public health agencies, state agencies (health, human services, and education) and other experts in the field of home visiting.

/2004/Reflecting additional legislative changes, MHB, the universal home visiting program ends 31 December 2003. The statewide Family Home Visiting Program (FHV) is now one activity Community Health Boards (CHBs) and tribal governments can continue with TANF funds under the Local Public Health Act. Local public health grant funds may be used for universal and/or targeted home visiting strategies. //2004// **/2005/ As a result of structural changes this unit was renamed Newborn and Child Screening. Family Home Visiting is now part of Perinatal Health. Universal Newborn Hearing screening funding was extended to 3/30/05. The CDC Early Hearing Detection and Intervention (EHDI) grant reapplication was submitted 4/29/04. MDH and Mayo Medical Laboratories developed a contract for supplemental newborn screening tests. 108 out of 111 birthing hospitals in MN are screening for hearing. //2005//**

Child and Adolescent Health Policy Unit: The Child and Adolescent Health Policy unit creates a focus for policy and system development and integration to assure that the health needs of children and adolescents are adequately addressed in future policy, program and service delivery arrangements. This includes assessment of child and adolescent health needs and provision of leadership to support health care reform activities, and community and systems development to improve arrangements for the delivery of an array of children's services. Specific attention is given to promotion of the health and safety of children in child care settings, school health (including hearing and vision screening), adolescent health, and children's mental health issues. Staff work closely with Coordinated School Health Project staff the Minnesota Children with Special Health Needs (MCSHN) Section as well as staff from related state agencies such as Minnesota Department of Education and the Department of Human Services. Unit staff provide leadership for technical assistance to local agencies receiving Youth Risk Behavior Endowment funding. /2003/Connections have been strengthened with the Department of Human Services Children's Mental Health Division and several joint pilot projects are in process, directed at the promotion or early identification of the social/emotional health needs of children. /2003/ Work is continuing on design of a comprehensive system for the safe administration of medications in Minnesota schools, anchored by the development of statewide standards and guidelines and local district policies and procedures. To provide expanded staff capacity for this activity it was necessary to discontinue Title V direct consultation and technical assistance to child care health consultants. Future support will be provided at a reduced level through the provision of web-based technical assistance information, communication networking and sharing, and connection to other state and national agency resources. /2004/ The unit is participating in and leading collaborative policy and planning efforts directed towards the integration of evidence based strategies to address the health and social-emotional development of early childhood. These efforts include several interagency collaborative grant applications and/or projects. In addition, the unit has increased consultative and collaborative activities with external organizations and advisory groups whose focus is early childhood development.//2004/ **/2005/ As a result of structural changes the work of this unit has been incorporated into different units and Sections in the Division. School health, adolescent health, communications are included as part of the new Integrated Support for Cross Divisional Activities Section. Administration of the SECCS grant is temporarily included in the Women's and Reproductive Health unit. Work is underway to construct a Child Health Unit. //2005//**

Fetal Alcohol prevention(FAS) Unit: The mission of the Unit is to strengthen the capacity of Minnesota communities to prevent prenatal exposure to alcohol and other drugs of abuse. Current programs include: the Community Grants Program, Fetal Alcohol Related Effects Study, Media and Public Information Campaign, Professional Education, and technical assistance and capacity building including development of public policy. Effective July 1, 2002, the FAS primary prevention activities were integrated into the Maternal and Child Health Section. /2004/ Activities have expanded to include broader areas of perinatal health and substance abuse prevention activities including use of tobacco and other drugs. Research activities have ended due to budget constraints. //2004// **/2005/ As a result of structural changes the FAS unit has been expanded to include Family Home Visiting and Infant Mortality and is now the Perinatal Health Unit. Due to legislative changes,**

***state funds that supported FAS prevention were redirected to a single non-profit agency to implement FAS Prevention programming. In 2003, MDH received a five year CDC grant for prevention of alcohol use by pregnant women.//2005//***

C. Minnesota Children with Special Health Needs (MCSHN). The MCSHN Section has a total of 28.20 FTEs funded by state appropriations [1.65 FTE]; MCH Block Grant [20.40 FTE]; Part C/Part B [5.15 FTE]; and Medical Home Grant [1.0 FTE].

The purpose of MCSHN is to improve the quality of life for Minnesota children and adolescents with special health needs and their families. The MCSHN Section is structured into two units: the Research/Policy and Analysis Unit and the Community and Clinic Services Unit. Direction is provided by the Section Manager and the two unit supervisors. The MCSHN Section Manager has a Master's degree in hospital and health care administration and has 10 years of experience in health planning, five in hospital corporation activities, 9 in maternal and child health and three in CSHCN. Staff are located within the central office (located in St. Paul) except for five district consultants each assigned to one of five out-state district offices. Staff include parents who have children with special health needs. Additionally, a panel of family consultants have been commissioned to provide suggestions, recommendations, and assistance to MCSHN programs.

With the emphasis on core public health functions, the MCSHN Section provides and supports a variety of services that sustain and enhance community-based systems of care. MCSHN provides medical, developmental and rehabilitative clinic services throughout the state where comparable services are not available; technical consultation and training to public and private providers and payers, families and other state and local agency staff; family support, information and referral; participation on local, regional, and state interagency collaborative groups; and involvement in or initiation of information, research and policy issues related to the MCSHN target population.

Diagnostic services are available to any child or youth under age 21 who is a Minnesota resident and is suspected of having a chronic or disabling condition. There are no family out-of-pocket expenses for this service. Treatment services are also available to any child or youth under age 21, who has a diagnosed medically eligible condition and meets MCSHN financial guidelines. Financial eligibility guidelines are based on 60 percent of the state's median income. Adults with hemophilia or cystic fibrosis may also be eligible. Some families may have a cost-share associated with eligibility. /2004/ In response to the state's budget deficit the MCSHN Treatment Program and the Evaluation Program were eliminated and the programs ended June 30, 2003. //2004// ***/2005/ MCSHN used the NICHQ model of a learning collaborative to initiate its Medical Home activities. Eleven pediatric practice teams were put together to begin medical home efforts. Each team is composed of a pediatrician, care coordinator and two parents. //2005//***

Clinics are a traditional component of the MCSHN program. MCSHN clinics provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs. They serve to complement local health care and are located in communities where such services are not in existence. MCSHN clinics are staffed by a multi-disciplinary team or specialist with pediatric expertise. ***/2005/ State Legislature appropriated an additional \$202,000 for expansion of clinic services. //2005//***

MCSHN also continues to disseminate its condition-specific Guidelines of Care for Children with Special Health Care Needs which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Deaf and Hard of Hearing, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure Disorder, Sickle Cell Disease, and Spina Bifida.

/2003/The state elected to use the MA-EPO (Medical Assistance for Employed Persons with a Disability) option for the adults with hemophilia or cystic fibrosis who were enrolled in the MCSHN treatment program. ***/2005/ MCSHN began to contract with institutional providers for the operation of several types of clinics. Gillette Specialty Health Care conducts Habilitation***

**Technology clinics for MCSHN. The International Diabetes Center of Park-Nicollet Clinic has for years conducted diabetes clinics for Minnesota youth. In the last year that contract has been renegotiated so the emphasis by IDC is to enhance community capacity and infrastructure rather than direct service provision //2005//.**

Community Systems and Development: The Community Systems and Development Unit (Team) provides a wide variety of activities at the local, regional, and state levels with public/private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow up, and program/policy development. /2003/Community and Clinic Services: The Community and Clinic Services Unit provides a variety of activities at the local, regional, and state levels with public/private agencies and families, including education and training, technical consultation, newborn metabolic screening follow up, and program/policy development.

Research/Analysis and Policy: The Research/Analysis and Policy Unit (Team) was created to support and help develop the capacity to collect and analyze data for research and policy issues. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions which positively impact children with special health needs. Specific activities and projects for both units are described later in this document, but also include information and assistance as well as child find and outreach.

D. Special Supplemental Nutrition Programs has a total of 26.5 FTEs funded by the U.S. Department of Agriculture. This Section of the Division of Family Health is comprised of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP). These two programs are designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. The populations eligible for these programs include: pregnant, breastfeeding, and postpartum women, infants, and children (up to the age of 5 for the WIC program and up to the age of 6 for the CSFP program). The CSFP program also serves the elderly population (age 62 and above). This Section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Indian tribal organizations to administer the WIC program; and to local food banks to administer the CSFP program. 2003/The WIC Program is currently revising policies to facilitate collaboration with MCH Programs such as Home Visiting. /2004/ WIC is currently at an all time high for the provision of services, serving approximately 110,000 persons per month. Minnesota was one of only a few states that provided state funding to support WIC services. The 2003 Legislative session redirected this funding (\$3.6 million a year) to the Local Public Health Grant. While Community Health Boards and Tribal Governments can use their Local Public Health Grant to fund WIC services they have the flexibility to redirect funding to other local priorities. To offer local public health increased flexibility in the use of funds provided by the state, legislation was approved allowing federal TANF funding available under the Local Public Health Grant to be expanded to cover WIC clinic services as well as the home visiting and teen pregnancy prevention activities already covered. //2004// **/2005/ Reflecting the economy, WIC participation continues to grow and WIC is now serving 117,500 participants monthly.//2005//**

**/2005/Integrated Support for Cross Divisional Activities Section. This Section has a total of 8.3 FTEs funded by MCH Block Grant [5.9 FTE]; Preventive Block Grant [.40 FTE]; SSDI [1.0 FTE]; CDC FAS Grant [.50 FTE] and Medicaid [.25 FTE]. This newly created section is responsible for supporting and strengthening cross-divisional activities which includes broad internal and external communication; how the Division uses data to monitor and evaluate programs and the health status of mothers and children, including children with special health care needs; emerging issues that require Division-wide input and monitoring as well as a special focus on adolescent and school health.//2005//**

## C. ORGANIZATIONAL STRUCTURE

A. State Department of Health: The Minnesota Department of Health (MDH) is one of the major

administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate. The Commissioner serves at the pleasure of the governor. Minnesota Statutes Chapter 144 contains the state law specific to the Minnesota Department of Health including its overall authority and many detailed requirements such as those related to vital statistics, health records, consent of minors for health services, lead absorption, children's camps, hospital regulation, etc. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. The Department is charged directly by state or federal law to perform four types of functions. These are: 1) to provide direct services, either to the public or to institutions which serve the public; 2) to provide consultation, training, and technical services to local health agencies and various professional groups working in public health-related fields or in occupations which can affect those working in public health-related fields or in occupations which can affect the health of the public; 3) to monitor local health agency programs which are subsidized by the state or supported with federal funds to assure effective and efficient delivery of services; and 4) to receive federal funds designated for public health and prevention purposes and distribute them to state and local programs in accordance with federal requirements and state health priorities.

The MDH is organized into an Executive Office and three Bureaus. Within the Bureau of Family and Community Health is the Division of Family Health, which is responsible for "the administration of programs carried out by allotments under Title V". The Division is organized into the Director's Office and four sections all of which engage in maternal and child health activities: Maternal and Child Health (MCH), Minnesota Children with Special Health Needs (MCSHN), Center for Health Promotion and Supplemental Nutrition Programs.

/2003/Effective July 1, 2002 a new Chronic Disease and Health Promotion Division was formed. The Center for Health Promotion and the Chronic Disease Prevention and Control Division were merged into the new Division. The new Division will be part of the Family and Community Health Bureau. **/2005/The Division of Family Health reorganized into four sections./2005//**

B. Local Public Health: The delivery of primary and preventive health care services by local government in Minnesota occurs within a framework governed by "Community Health Boards." The Boards themselves are comprised of elected officials, either county commissioners or city council members, although the Community Health Boards have the authority to appoint non-elected officials to the Board. The Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conduct of public health core functions and delivery of community public health services directly or through contracts. Program services include disease prevention and control, emergency medical services, environmental health, health promotion, home health and family health. There are 50 Community Health Boards in the state including 22 single-county boards, 66 counties cooperating in 23 multi-county boards, four cities, and one city-county board. /2003/ There are 50 Community Health Boards in the state including 23 single-county boards, 63 counties cooperating in 22 multi-county boards, four cities, and one city-county board. /2004/ There are 51 Community Health Boards in the state including 25 single-county boards, 61 counties cooperating in 21 multi-county boards, four cities, and one city-county board. //2004//

Boards must comply with a number of statutory requirements including a comprehensive assessment of the health status of the population for which the Board is responsible. This is done on a four year cycle with the resulting community health plan updated two years later. Budgets are prepared annually. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided by an ongoing state subsidy. However local funding is the major funding source. (\$19 million state subsidy, \$70 million local tax levy. Balance is grants, 3rd party payments, fees, etc. totaling approximately \$234 million annually.) /2003/ (\$19 million state subsidy, \$71 million local tax levy. Balance is grants, 3rd party payments, fees, etc. totaling approximately \$248 million annually.) /2004/ (\$19 million state subsidy, \$70 million local tax levy. Balance is grants, 3rd party payments, fees, etc. totaling approximately

\$274 million annually.) //2004// ***/2005/\$21 million state subsidy, \$10 million in federal categorical funds, \$57 million local tax levy. Balance is grants, 3rd party payments, fees, etc., totaling approximately \$292 million annually. //2005//***

In keeping with the requirements of state law two-thirds of the MCH block grant is allocated to the state's 51 Community Health Boards through a formula.

C. Maternal and Child Health Special Project Grants Program: The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's Community Health Boards. MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in four statewide priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, and childhood injury prevention. Additionally, certain child and adolescent health services are authorized for the cities of Minneapolis and St. Paul and the counties of Goodhue and Wabasha.

Over the last few years, several changes in maternal and child demographic data and risk factors have occurred and the MCHSP funding formula was determined to be in need of revision. Accordingly, in 1998 a work group of the Maternal and Child Health Advisory Task Force was formed to develop recommendations for updating the funding formula. The result included recommendations for a new formula, a new funding floor, and policy changes including authorization to provide child and adolescent health services statewide. This recommendation was accepted by the Commissioner of Health and introduced into the 1999 legislative session but was not enacted into law. It was reintroduced into the 2001 legislative session but again not enacted.

//2004//The 2003 Legislature consolidated the MCHSP grant program, along with seven other categorical programs, into one grant. State appropriations, the MCH Block Grant, and federal TANF funds fund the resulting Local Public Health Grant (LPHG) . The LPHG provides funding for Community Health Boards and Tribal Governments however; only Community Health Boards receive MCH Block Grant funds. The LPHG moves from a planning (what are you going to do) to a more results based-outcome driven process. Use of MCH Block Grant funds are statutorily limited to: improved pregnancy outcomes, family planning services, services to children with special health care needs, preventive care for children and adolescents, home visiting services and WIC clinic services. Initial outcome related to the MCH Block grant funding is "to work toward the 2010 goal to reduce the percentage of low birth weight babies". The MCH Task Force and State Community Health Agency Committee will suggest additional outcomes to the Commissioner of Health before January 1, 2005. Local match for the MCH funds was raised from 25 percent to 50 percent. //2004//

//2004//D. Tribal Governments: While the Department of Health and the Division of Family Health had been working with tribal governments for some time, the process became more formalized in 2003 with the establishment and the hiring of a Tribal Liaison. Located within the Community Health Service Division, the position is uniquely situated to establish stronger ties with Tribal Governments and Tribal Health Directors. Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies tribes were directed to use the new money for maternal and child issues. During the course of the next six months, the tribes, working with the Department will identify outcomes for the LPHG. //2004// ***/2005/ This position and the activities it oversees are now located within the Office of Minority and Multicultural Health. //2005//***

## **D. OTHER MCH CAPACITY**

See B. Agency Capacity for a description of the number and location of staff that work on Title V programs. Senior level management bios are also included in this area.

MCSHN program has, since FY 2000, had a Family Consultant Advisory Group. Consisting of up to eight parents, this group has brought to MCSHN policy discussions the voice of parents and their children.

Parents who had been through previous advocacy and or leadership programs were selected. Most parents were either graduates of Parents in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early Learning Design {MELD} Special Parent trainings. Parents demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his/her selection. The Family Voices representative in Minnesota has provided administrative oversight to the Advisory Group.

These parents are actively caring for children with special needs in their families and communities and have constantly been required to adapt to changing conditions. Next to their children, parents have the most to gain in achieving positive outcomes and this produces significant incentives and commitment to improving systems of care. Parents perceive programs, policies and procedures through practical insight and share that wisdom with staff.

During this past year the Advisory Group has been meeting monthly to review the six core outcomes of the Bureau's ten-year action plan and are framing specific actions for the state's work plan. ***//2005/ Parent meetings have continued and have focused on health disparities documented by the MCSHN program through analysis of the Minnesota Student Survey. Parent meetings have also focused on important transition issues of responsibilities of local public health agencies brought about by the 2003 legislature which dramatically changed the funding of local public health because of the significant deficit that the legislature was faced with. //2005//***

Several MCSHN staff are parents with one or more children who have a special health care need. The roles these parents perform in the program range from supervisory to policy and program planning to technical consultation for statewide programs.

## **E. STATE AGENCY COORDINATION**

### **A. Relationship Between State and Local Public Health Agencies**

See: C. Organizations Structure, B. Local Public Health

### **B. Coordination with Office of Rural Health and Primary Care**

The Office of Rural Health and Primary Care is in the Division of Community Health Services of the Minnesota Department of Health. Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. ***//2005/ The MCH Mental Health Coordinator is working closely with the Rural Health Advisory Committee on their priority for the year -- mental health issues in rural Minnesota. Focus areas include resources and provider capacity, and system issues rural Minnesota in the area of mental health. //2005//***

### **C. Coordination with the Tobacco Prevention and Control Program (TP&C)**

The Title V MCH Section and TP&C continue to work together to address tobacco prevention among children and families in Minnesota. The Tobacco Prevention and Control Section is in the Division of Community Health Services of the Minnesota Department of Health and coordinates and links a variety of state and federally funded activities targeting youth tobacco use prevention. A major focus this past year has been the Minnesota Youth Prevention Initiative. In 1999, the Minnesota Legislature set aside \$492 million in tobacco settlement money from the state's tobacco lawsuit with a goal of reducing tobacco use among Minnesota young people by 30 percent by the year 2005. Using the

interest earned from the endowment, efforts are focused on five focus areas: youth access, tobacco pricing, school-based programs, and secondhand smoke and cessation linkages. The endowments target youth but the tobacco Section's prevention efforts include a broad population tobacco prevention effort as well.

/2003/ The resources of the Tobacco Use Prevention and Local Public Health Endowment are at work in communities across the state. Using approximately eight percent of the revenue from the historic settlement between the state and the tobacco industry, communities across the state are working hard to reduce the number of teens using tobacco products and engagement in other risk behaviors. As community efforts enter their second year, early indicators show that all of the hard work and resources are paying off.

In accordance with funding guidelines provided by the Legislature, MDH was allocated \$17,460,935 for distribution through the Minnesota Youth Tobacco Prevention Initiative (MYTPI) to reduce youth tobacco use by 30 percent by 2005. It also dispersed \$3,450,364 through the Youth Risk Behavior Initiative (YRB) for health promotion and protection activities aimed at high-risk behaviors among youth. During the 2002 legislative sessions, proposals for changing allocations from the tobacco endorsement were considered but not enacted.

/2004/ Over the past three years, the resources of the Tobacco Use Prevention and Local Public Health Endowment have been at work in communities across the state. Using approximately \$22 million per year, communities have worked hard to reduce the number of teens using tobacco products and engagement in other risk behaviors. Data from the Youth Tobacco Survey indicate that these efforts contributed to an 11 percent reduction in youth tobacco use from 2000 to 2003.

The 2003 Minnesota Legislature set a new goal of reducing tobacco use among Minnesota young people by 25 percent by the year 2005, and has budgeted \$3.3 million per year towards this effort starting in July 2003. This reduction in funding for youth tobacco prevention efforts will require an even greater effort to partner with similar programs at the state and local level. State funding will be used for community-based grants that will develop a plan for youth tobacco use reduction using proven effective strategies. //2004// ***/2005/ The network of youth risk behavior activity previously funded by the tobacco endowment has done it's best to maintain partnerships and activities at the local level, but most programs have been so severely reduced that the statewide network has unraveled. Staff from the tobacco prevention and control unit however have become important partners in the Robert Wood Johnson/ ACOG/Planned Parenthood project on smoking cessation for pregnant women and have committed .5 FTE to this area of work. //2005//***

#### D. Coordination with Other Governmental Agencies

1. Department of Human Services (DHS): The Title V program and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. See Title V-Title XIX Interagency Memorandum of Understanding . Current collaborative efforts include the Family Service Collaboratives and the Children's Mental Health Collaboratives. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Title V staff participate in planning for the Children's Health Insurance Plan, Medicaid Pilot Projects for Persons with Disabilities, TANF-funded activities around Home Visiting and Teen Pregnancy Prevention, as well as EPSDT to name a few. The collaborative activities listed above are described in more detail in other sections of the annual report and application. Formal contracts exist which provide DHS funding for staff in the Title V program relative to EPSDT, and services to deaf, hard of hearing, and deaf-blind individuals. Management staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest. ***/2005/ Min has several early childhood programs administered by DHS and the Department of Education (DOE) that assist families and provide quality services for children. The successful administration of the MN Early Childhood Comprehensive System of Care (MECCS) grant, administered by MDH will require significant collaborative work with DHS and DOE. //2005//***

2. Department of Children, Families and Learning: The Title V program and the Department of Children, Families, and Learning (DCFL) collaborate on many projects and programs: Family Service and Children's Mental Health Collaboratives, Part C, Coordinated School Health, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. The above projects and programs are described in more detail in other parts of the annual report and application. Interdepartmental planning around alcohol and other drugs usage by youth is also occurring. DCFL is the fiscal host for the Interagency STATES Incentive Grant. //2004/ The 2003 Legislature changed the Department's name to Minnesota Department of Education to highlight its priority mission of education. Programs that did not support this mission were transferred to other Departments (Child Care to the Department of Human Services). //2004// ***/2005/ In State Fiscal Year 2004, MCSHN expanded its Interagency Agreement with MDE to include Part B as well as Part C (of IDEA) responsibilities. The Minnesota Departments of Education, Health and Human Services, along with an array of other state and local public and private entities successfully advocated for continuation of the Minnesota Student Survey this year, when it was under consideration for elimination. This survey of youth health and risk status and behaviors is a critical assessment, evaluation and planning tool for Title V work particularly since Minnesota has not participated in the CDC YRBSS.//2005//***

3. Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and children's mental health issues provide avenues and linkages to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

4. Department of Public Safety: The MDH Injury and Violence Prevention Unit continues to address the public health problem of childhood motor vehicle injury by emphasizing correct installation of child safety seats. The unit has co-sponsored installation training sessions across Minnesota, teaching local hospital staff and public health professional's current installation techniques and procedures. A recent observational study in Minnesota found that nearly 80 percent of children in child safety seats were restrained incorrectly.

Collaboration with the Minnesota Center for Crime Victims Services is focused on support of community-based programs providing assistance to sexual assault victims. Preventive Health and Health Services Block Grant funds from the MDH are used, in part, to support programs at the Department of Corrections and its grantees for the prevention of sexual assault. These block grant funds also have supported activities to develop a sexual violence prevention resource kit for use by local public health agencies and others interested in violence prevention.

5. Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently, minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

6. Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, this list has been included in the work of the Family Support Minnesota formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures; and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

7. II. Part C of IDEA (Individuals with Disabilities Education Act) -Early Childhood Intervention: Minnesota's Early Childhood Intervention Program (Part C) is a joint initiative of three state agencies: (Health; Human Services; and Education and local IEICs (Interagency Early Intervention Committees). The Minnesota Department of Education is the lead agency in Minnesota. Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the Minnesota Children with Special Health Needs (MCSHN) Section. The Part C health team works closely with MDH staff. MCSHN provides time to the Part C project on the mandated State Agency Committee (SAC) and the Governor appointed Interagency Coordinating Council (ICC).

The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The team has primary lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system. The team is completing a special research project (Enhanced Follow-up) which consists of a survey of children 0-3 to determine the number of children "at risk" for developmental delay and service needs. /2004/ Part C contributes substantially to the core outcome of early and continuous screening for all children. Articulating the role of Public Health in the interagency early intervention system at both the state and local levels through training, technical assistance, and materials development has encouraged a population-based approach to the population in this state where eligibility for early intervention excludes much of the "at risk" population. /2004/ ***/2005/A pilot study of mental health screening was begun by adding the social-emotional component to the ASQ during SFY 2003. It was successful and is now being implemented statewide. //2005//***

8. University of Minnesota: Collaboration between the Title V agency and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program of the School of Public Health participates in the Department's Maternal and Child Health Advisory Task Force and the Department's Title V program is collaborating with the school's MCH program community education activities including presenting at its annual summer Institute for Addressing Health Disparities. A number of Title V program staff are graduates of the program. In addition, a number of MPH students have completed internships in the Division of Family Health over the past several years.

The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused

programs across the state.

The MCH Reproductive Health Unit staff also collaborate with the National Teen Pregnancy Prevention staff on numerous projects including the development of a state teen pregnancy prevention and parenting plan.

/2003/ Another collaboration is a new initiative called the Minnesota Center for Research in Health Statistics involving collaboration between the University of Minnesota, School of Public Health Staff and the MDH. The current Director of Community Outreach for the MCH Training Program formally was the Reproductive Health Planner in the Division of Family Health.

***/2005/ The MCSHN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CSHCN. The latter is partly funded by the MCH Bureau. In addition, MCSHN, the School of Public Health and the Center for Urban and Regional Advancement (CURA) of the Humphrey Institute are working together to evaluate MCSHN Developmental Behavior Clinics. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. We are currently discussing a shared Women's Health Website. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. MCH staff again participated in planning the annual MCH Summer Institute put on by the MCH Department at the School of Public Health. MCH epidemiology staff from the University have been helpful in planning, recruiting, and hiring for a new MCH Epidemiologist position at MDH. //2005//***

9. Coordinated System for Children with Disabilities Aged Three to 21: As a result of legislation in 1998, the state has in place a law mandating a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. This system is to be modeled after Part C. The law requires a phase in of the system, by age groups over five years with the last group of children aged 14-21 phased in by July 2003. Staff from MDH have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and others, as well as the many workgroups engaged in identifying barriers and funding sources, establishing policies and direction, designing an evaluation methodology, and developing products for use by local county boards and school boards including sample governance agreements and a standardized written plan. These activities will continue and staff will continue to participate to assure that the system meets the needs of children with special health needs.

/2004/ Several workgroups are actively engaged in developing guidance materials for local areas: Interagency Individualize Intervention (IIIP) Workgroup- This group has as its responsibility the development of a format for an individualize plan integrating the required data elements or components of 9 different plans. Other plans are to be coordinated through this planning process; Shared Outcome Workgroup which is developing guidance on how to write a plan with coordinated goals and objectives address the needs of the child/student/young adult across home, school and community instead of separate ones; Evaluation workgroup to design and implement evaluation plan; Coordination of services workgroup that is exploring the maximization of current federal and state dollars to support this activity including service coordination; Birth to 21 Advisory group made up of local service providers and families to provide input on system design issues and products; Training - Train the trainer events were developed to provide this technical assistance and training to local areas so that they could in turn train their local areas and providers. Each area of the state designated a team made up of health, human services, education, family service collaboratives, and families. /2004/

10. Tribal Governments: In November 2000, the MDH partnered with the Department of Human Services (DHS) in a conference "Sovereignty: The Health of the Matter", a conference on the state of health care for American Indians in Minnesota. In follow up MDH Staff entered into discussions with DHS and Tribal Health leaders resulting in an invitation of MDH participation in the quarterly Indian Health Directors meetings staffed by DHS.

The MCH Director has attended several meetings of the Minnesota Indian Affairs Council which are attended by the elected Tribal Chairs. This provides an opportunity for developing relationships, enhancing understanding, and sometimes presenting on specific issues and getting advice from the Tribal leaders.

For the statewide Community Health Boards conference in fall of 2001, a presentation was given by the MDH Deputy Commissioner and the Director of the Indian Affairs Council, to share with local county and public health officials, concerning the changing and growing intentions and activities of MDH work with the Tribes.

Collaboration with the Tribal health directors and Indian Health Services staff resulted in development of formulas through which MDH could disperse grant dollars directly to Tribes, rather than have them go through local county public health agencies. Two activity areas were funded: TANF dollars for home visiting, and eliminating health disparities in the health area of the tribes' choice (infant mortality, cardiovascular health, diabetes, teen pregnancy prevention, injury reduction, etc.

/2003/ Considerable effort has gone into enhancing relationships with Tribal health staff and Tribal Chairpersons. In April 2002, MDH co sponsored with DHS the second annual conference "Sovereignty The Health of the Matter", attended by both tribal, state and health and human service staff. Quarterly meetings of the Tribal Health Directors were hosted. These are half day meetings that provide opportunity for information sharing and discussion around issues of health and social services between the state MDH and DHS and Tribal Health staff leadership. /2003/

/2004/The 2003 Legislative Session directed \$1.5 million a year to tribal governments to improve the health and well-being of mothers and children and to reduce health disparities. The staff in the Division of Family Health will continue to provide technical assistance and support to tribal governments as they design and begin to implement programs to reach these goals. /2004/

***/2005/ Title V continues its leadership and commitment to support work with American Indians in Minnesota. Activities include: planning for and attending quarterly Tribal Health Directors meetings; supporting internal department wide meetings on American Indian health; traveling with our MDH Tribal Health Coordinator for site visits to several reservations; working with the MDH Tribal Health Coordinator to provide information, resources and support for the American Indian Health Grants made directly to Tribes in Minnesota.//2005***

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

All health systems capacity indicators will be reported annually. Among the nine indicators, one is new (9C) and one has been converted from a developmental health status indicator to a health systems capacity indicator (9B). The areas addressed by these measures are: adolescent use of tobacco products (9B) and proportion of overweight/obese children (9C). The capacity of the Minnesota state health system to gather data and track progress on these two health-related conditions will be determined by its ability to effectively maintain and expand an effective survey system and its ability to successfully link relevant databases.

Currently, the statewide Minnesota Student Survey (MSS) provides biennial data on all students in grades 9 and 12 regarding their use of tobacco (6 questions) as well as weight, dieting, and eating patterns (3 questions). However, weight-related questions are based on individual perception rather than objective verification of actual overweight, and the target population does not include younger children. Furthermore, the MSS is conducted only on alternate years, the most recent during the 2001-02 school year; the next wave is scheduled for 2003-04. An additional survey which specifically addresses adolescent tobacco use is the Minnesota Youth Tobacco Survey (MYTS). It is administered to a statewide sample of students in grades 6 through 12 and contains 72 questions all related to tobacco use. MYTS was first administered in 2000 and again in 2002 as an outgrowth of tobacco settlement funds; a third wave is planned for 2005. Merging data compiled from both the

MSS and MYTS should yield a valid and reliable determination of adolescent tobacco use, thereby providing a solid systems indicator.

An indicator of increased systems capacity--particularly in tracking childhood obesity trends--would be implementation of the CDC-sponsored Youth Risk Behavior Surveillance System (YRBSS), which is currently under consideration in this state. YRBSS could be administered on an annual basis to students in grades 9 through 12 and would provide both additional weight and tobacco-related data. YRBSS asks adolescents for specific weight and height measurements, from which obesity or excess weight could be more objectively determined, and it includes sections on physical activity and nutrition as well. It does not address overweight/obesity in younger children, however. In order to achieve the latter, we will need to develop a mechanism for monitoring children's health through the early and middle years. The most effective method will be to link birth records with WIC data, as well as with school records. We have noted increased rates of high birth weight babies in recent years, particularly among populations of color and American Indians. Birth weight data could provide additional insight if linked with elementary and secondary school health data. A data linkage project is currently in the formative stages. It will link MDH data with several other state agencies, as well as with the Center for Advanced Studies in Child Welfare at the University of Minnesota.

In summary, our current capacity to provide valid and reliable data on adolescent tobacco use is much greater than our capacity to provide such data on children's weight issues. An indicator of increased systems capacity in the tobacco area would be availability of annual data through use of multiple surveys (2 or 3). Indicators of enhanced capacity in determining and tracking childhood overweight/obesity would include mandatory annual recording of height/weight on all student records, followed by successful linkage of birth records with school records--as well as an efficient process for retrieval of such school data. In future years, determination of the social and environmental context surrounding tobacco use and excessive weight gain would also indicate increased systems capacity.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

The most important priority for the Minnesota Children with Special Health Needs (MCSHN) program is to develop both a strategic and practical approach to implement activities that address the six core outcome measures adopted by the Bureau to measure success on issues affecting CSHCN and their families by the year 2010. Specific activities addressing each of the six core outcomes are being developed along a number of venues using the same approach, which in essence is a variation of the Delphi method used by researchers. Parent consultants, health department staff and targeted community leaders will continue to be presented with the background of the six core outcomes and the outcomes themselves. Their advice on actions is then translated into specific work activities with each iteration further refining the specific actions. It should be noted, this is taking place within the context of a time period that is experiencing substantial program and budget changes. The next year will be spent sorting through those changes and their individual, interrelated and cumulative effects.

Minnesota, like other states, has responded to the restatement of the national performance measures with data supplied by the National Survey of Children with Special Health Needs. The state will continue to explore partnership opportunities with academic and nonprofit organizations to further analyze the data from this survey. Specific program activities that flow from this framework include the MCSHN activities in medical home development, integration of newborn screening program and data, partnerships with families and advocacy organizations and continued leadership in interagency collaboration activities directed to simplify and coordinate delivery of services to children with disabilities.

The leading priority for the MCH part of the Title V program is the identification of current data and epidemiology capacity and needs. Within that framework, program activity will focus on women's' health, child health and youth/adolescent health. Women's' health activities will concentrate on perinatal health. Child health activities will revolve around health promotion plus early identification and intervention, especially in areas such as ESPDT, fetal alcohol syndrome, hearing detection and prevention, genetics and infant mortality. Youth and adolescent health will center on teen pregnancy prevention and on school health.

Minnesota achieved a number of the annual performance objectives as well as health outcome measures for this year. Revisions in annual performance objectives occurred for the following:

- NPM # 08: The rate of birth for teenagers aged 15 through 17 years.
- NPM # 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
- NPM # 17: Percent very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
- HOM # 02: The ratio of the black infant mortality rate to the white infant mortality rate.
- HOM # 03: The neonatal mortality rate per 1,000 births.
- HOM # 06: The child death rate per 100,000 children aged 1 through 14.

The discretionary performance measures identified by Minnesota culminated from a process designed to assure selection of measures based upon the views of the broad array of MCH stakeholders. External work group members who participate in the process included representatives from local public health agencies, the Department of Human Services, Children's Defense Fund -- Minnesota, Office of Multicultural and Minority Health, local health care providers, and the University of Minnesota School of Public Health.

Two of Minnesota's discretionary performance measures have subsequently become inactive, as the state met the outcome objective. These two measures were: SPM#7 Percentage of counties with a Children's Mental Health Collaborative or a Family Service Collaborative and SPM #8 The percentage of MCH plans that include objectives and methods to eliminate the disparity in health status between populations of color and the majority population. A new discretionary performance measure was identified: SPM #10 The percentage of children, birth through 21 years of age, eligible to have an

Individual Intervention Plan (IIIP) who have a IIIP.

This performance measure was chosen because it strongly supports a coordinated, community-based, family-centered system of care. It supports the state's priority need "Promote family support and healthy community conditions" and "Increase the percent of children who receive early intervention services". While currently only a small percent of eligible children are involved in the IIIP process receive IIIP services, it is the intent of the state that this process will ultimately encompass most children receiving services through multiple state agencies.

Minnesota has endeavored to maximize non Title V resources to support direct health care services. The use of Title V funds for the purpose of direct health care services is very limited; however in its assurance role some funding is available. It is state policy that direct public health services are delivered locally to the extent possible. Accordingly, the state Title V program for cshcn (MCSHN) delivers some direct services but the MCH delivery of direct public health services occurs entirely at the local level with the state MCH program engaged in administrative activities supporting direct health care delivery system. ***//2005/ The state conducts a biennial survey of its 6th, 9th and 12th grade students in public schools. Surveys conducted in 1998 and 2001 document significant health disparities between CSHCN and their same age peers on several dimensions such as attempted suicide. MCSHN will make this a policy priority over the next few years. //2005//***

## B. STATE PRIORITIES

The priority needs were identified through a process that culminated in the statewide mailing of the MCH/MCSHN Priority Needs Menu to members of the Maternal and Child Health Advisory Task Force and MCH Needs Assessment 2000 Work Group, local public health agencies, and public health nursing directors. The menu was developed by MCH and MCSHN staff based on the recommendations of the Work Group and Advisory Task Force. Items included in the menu were derived from the MCH Indicators Menu results and the findings and recommendations of focus groups conducted by the Wilder Research Center, the Minnesota Department of Health, the Urban Coalition, and MOAPP.

The needs so identified include (not in priority order):

- Reduce drug, alcohol, and tobacco use
- Promote family support and healthy community conditions
- Promote healthy parenting/family development
- Reduce child abuse and neglect
- Reduce teen pregnancy and teen birth rate
- Address the multifaceted needs of teen parents
- Increase percent of children whose disability is identified early
- Reduce youth risk behaviors
- Improve mental health of children, youth and parents
- Increase percent of children who receive early intervention services

The Minnesota Title V Program will place emphasis on these priorities and other sources of direction such as the MDH Strategic Directions. Since one of the Strategic Directions is "Elimination of Disparities," this is an element of all of the above ten priorities.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

This performance measure serving all newborns is related to the state priorities: "Increase percent of children whose disability is identified early". (Program and Resource Allocation: Direct Health Care; Enabling Services; Population-based services; Infrastructure Building).

Annual report: The percentage of newborns screened has remained stable at just over 99% since 1996. Pursuant to the revised 2003 state statute increasing newborn screening fee by \$40 per screen, all newborns must be screened for phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, and hemoglobinopathies and over thirty rare disorders found by tandem mass spectrometry (MS/MS) including disorders of amino acid metabolism, organic acidemias and fatty acid oxidation disorders. The Newborn Metabolic Screening Program tests samples taken from newborns, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This program is operated as a partnership of the Family Health Division and the Public Health Laboratory Division.

Activities in 2003 focused on implementing procedures for identifying and reporting disorders and determining recommendations for diagnostic testing. Program capacity was improved with increase in lab staff resulting in 1) ongoing refinement of laboratory "cut-off" values 2) improving repeat tracking procedures; 3) orienting and building proficiency and training of all program staff; 4) integrating data base and program procedures for previous tests and new conditions; 5) improving and standardizing notification procedures for presumptive positive screens; 6) enhancing following up presumptive positives for all disorders; 7) updating the website and newborn screening brochure; and 8) developing and implementing a submitter Quality Assurance "report card" 9) providing expanded education and technical assistance to hospital staff, professionals and others.

Integration between the newborn blood spot screening program and universal newborn hearing screening program resulted in a common reporting form, improved infant tracking and provider and consumer education as well as website linkage. Minnesota continues under a cooperative agreement through MCHB/HRSA to support implementation of the State Genetics Plan. This is being used to enhance, expand and integrate current activities around both newborn screening programs.

## b. Current Activities

Newborn screening program is incorporating 2003 legislative changes into the newborn screening program including 1) formalizing the Newborn Screening Advisory Committee 2) implementing UPS specimen pick up statewide 3) educating hospital staff, others about the expanded mandated screening tests and new opt out provisions, 4) initiating a contract with Mayo Clinic for MS/MS screening and second tier testing for congenital adrenal hyperplasia to reduce the number of false positives for this disorder.

The newborn screening fee increase and support through the MCHB/HRSA cooperative agreement further provides program and data coordination and an increase in lab, administrative support, IT, and follow up program staff resulting in improved notification and tracking for abnormal newborn screens, development of provider and consumer educational materials and increased collaboration between newborn blood spot and hearing programs and programs within Minnesota Department of Health. A pediatric nurse practitioner and newborn screening follow up staff are assisting families of infants found with metabolic, endocrine and hearing disorders.

There are such resources as medical home, pediatric specialists, genetic counseling services, high-risk follow-up programs, early education, WIC, and financial programs such as Medical Assistance, MinnesotaCare and others.

## c. Plan for the Coming Year

Emphasis will be placed on 1) improving repeat tracking and improving documentation in the

data base; 2) strengthening the education component with the medical home provider when presumptive positives are identified; 3) expanding outreach, education and technical assistance activities related to newborn screening 4) exploring an expansion of the Mayo partnership in areas of screening, clinical protocols and research applications; 5) improving hemoglobinopathy and endocrinology communications and support; 6) developing screening brochures in multiple languages; 7) linking birth certificates with newborn blood spot screening 8) expanding care coordination to a population of individuals with sickle cell disease and related disorders 9) implementing a newborn screening system for biotinidase deficiency. The Program will continue to strengthen relationships with statewide population based programs such as MCSHN, Universal Hearing Screening Program, high risk Follow Up Programs, and early education. The Newborn Screening Advisory Committee, which includes Title V staff, will maintain a key role in identifying future program directions and priorities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### a. Last Year's Accomplishments

This performance measure serves children with special health care needs and is related to the state priority: "Promote family support and healthy community conditions" and " Promote healthy parenting/family development." (Program and Resource Allocation: Population-based Services and Infrastructure Building).

Annual report: Since 2000, parents have participated in the role of Family Consultant advisory group to the MCSHN program. Recruitment, support and reimbursement for their time and expenses occurs through a contract with the PACER Center of Minnesota. A PACER center staff person was the Family Voices representative in Minnesota and she implemented the deliverables in this contract.

Parents who had been through previous advocacy and/or leadership programs were selected as participants. Most parents were either graduates of Partners in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early Learning Design [MELD] Special Parent trainings. Each parent had demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his or her selection. Contract goals for Fiscal Year 2002 were 1) to continue the dialogue with the Family Consultants with respect to roles and responsibilities associated with various opportunities for parental input on MCSHN activities and 2) to assist MCSHN staff to work effectively with the Family Consultants.

Parent involvement included reviewing and providing input into the Title V Block Grant report and application; other grant applications; and the medical home newsletter. Parents participation continues on the medical home advisory group, on a Department of Education work group that reviewed medication management issues in schools, and on the MCH Advisory Task Force.

Parents actively caring for children with special needs in their families and communities are constantly required to adapt to changing conditions. Since, parents have much to gain by achieving positive outcomes, they have significant incentives to improve systems of care and are committed to the process. Because they receive services, they have practical insight and wisdom to share with MCSHN staff. MCSHN staff are beginning to refocus planning and processes to assure that Family Consultants have direct and meaningful input into and influence on systems, policies, programs and practices.

## b. Current Activities

Parent input will be included in the process and outcome evaluation of MCSHN clinic operations. Clinics are conducted throughout rural Minnesota and are held for children requiring facial-dental, habilitation technology, developmental behavior, or diabetic services, as well as assessments. MCSHN entered into a contract with the University of Minnesota School of Public Health and the University of Minnesota Center for Urban and Regional Affairs (CURA) to evaluate the outcome(s) of MCSHN Developmental Behavior Clinics, which will include parent input. MCSHN staff revised strategies for implementation of state-defined public health goals and objectives (Healthy Minnesotans-2004), including strategies for family-centered care. Family consultants are also updating the related public health objectives in the Healthy Minnesotans plan through the year 2010.

## c. Plan for the Coming Year

The Parent Consultant group will continue to meet monthly to advise MCSHN on both public health and CSHCN activities. Members of the parent consultant group will continue to serve on advisory committees and will continue to participate in the expert panel process for the development of standards for the administration of medications in schools project. MCSHN will work with parents and parent advocacy groups to implement the program changes enacted by the 2003 legislature. The recommendations of the outcome evaluation study of Developmental Behavior Clinics will be implemented. Parent focus groups will be used in the 5 year Needs Assessment process currently underway.

*Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

## a. Last Year's Accomplishments

This performance measure serving all children with special health care needs is related to the state priorities: "Promote family support, and healthy community conditions"; "Promote healthy parenting/family development"; "Improve mental health of children, youth and parents"; and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Enabling Services; Population-based Services; Infrastructure Building).

The percentage of Minnesota's children with a medical home as defined by the AAP is disappointing. Access to ongoing primary care does not assure access to a medical home. To achieve this performance objective, improved physician understanding of the elements of a medical home is needed as well a change in family expectations of caregivers.

Minnesota was fortunate to be one of ten states selected by the American Academy of Pediatrics to participate in the AAP national medical home conference held in early 2001. MCSHN, The American Academy of Pediatrics-MN Chapter and Family Voices Minnesota attended. Throughout the past several years this physician -- parent -- public health partnership refined the vision for children with special health needs for the medical home relationship and created an action plan to bring that vision to fruition.

Other Title V activities included physician outreach and training; the development of materials focusing on improving care coordination, cultural competence and family-centered care; and local training and technical assistance for parents and professionals integrated into the Family Home Visiting Program and C&TC trainings.

## b. Current Activities

Minnesota continues to implement a Medical Home grant from MCHB. The MCSHN program is the direct grantee; subgrantees include the state AAP and Family Voices of Minnesota. Work is proceeding well with 10 physician-parent teams across the state and the expanded training offered through the Minnesota AAP Chapter to all pediatricians. The Medical Home concept is being incorporated into the work of the MCHB State Genetics grant as well as the Newborn Screening activities. The MCSHN program also is working with colleagues in the Environmental Health Division of the Minnesota Department of Health who have a CDC grant to examine the birth defects registry approach to assurance of services. MCSHN continues to include medical home concept in all appropriate contractual arrangements.

### c. Plan for the Coming Year

During the final year of its Medical Home grant the program will work to fulfill grant objectives, including working with both the state chapter of the AAP and the state's Family Voices organization. MCSHN will also continue to integrate medical home concept into the work of the Division and Department. The activities of the State Early Childhood Comprehensive System grant will also assist in integrating efforts to promote a medical home for all children through coordinated outreach screening and referral.

*Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

### a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; Increase percent of children whose disability is identified early" "Increase percent of children who receive early intervention services" "Improve mental health of children, youth and parents." Program and Resource Allocation: Direct Health Care; Population-based Services; and Infrastructure Building)

MCSHN district staff organized and conducted training sessions for parents and professionals. These training sessions, called MAZE trainings, provided up-to-date information on the state's publicly funded programs including Medical Assistance (Medicaid), MinnesotaCare, TEFRA, and other community-based waiver programs. MAZE presentations are made in community settings throughout the state. MCSHN Intake and Assistance staff spent considerable time and effort in transitioning eligible families to Medical Assistance and other public and private programs. Staff also participated in the state's Cover All Kids insurance initiative.

Changes made during the 2003 Legislative session (elimination of the MCSHN Treatment program; significant increase in parental costs for children on TEFRA, reduction of waiver slots, and beginning July 1, 2004 reduction in eligibility for children 2-18 from 170 percent of FPG to 150% FPG) challenged current strategies for assuring that families have adequate insurance to pay for their child's needs. The MCH Advisory Task Force has identified monitoring the impact of changes made in the 2003-2004 legislative sessions as a priority work activity.

### b. Current Activities

The major issue with meeting this performance measure will be the impact of changes to the state's publicly funded programs that occurred in the 2003-2004-legislative session. MCSHN is using parent consultants and experience with the MAZE trainings to update parents and professionals on these changes. The MCH Advisory Task Force workgroup is aggressively moving forward in identifying issues related to eligibility changes to public programs.

### c. Plan for the Coming Year

Continue activities as stated.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

### a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; "Improve mental health of children, youth and parents"; "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Population-based Services and Infrastructure Building).

MnSIC stands for Minnesota System of Interagency Coordination, a multi agency effort "to develop and implement a coordinated, multidisciplinary, interagency intervention service system for children" from birth to 21 with disabilities. Service coordination through an Interagency Individual Intervention Plan (IIP) is encouraged for services provided by special education and one or more of the following programs: the state MCH program, IDEA, Medical Assistance (Medicaid), Developmental Disabilities and Bill of Rights Act, Head Start, Rehabilitation Services, Juvenile Court Act, Children's Mental Health Collaboratives, Family Services Collaboratives, Family Community Support Services, MinnesotaCare, Community Health Services Grants, Community Social Services Act and Community Transition Interagency Committees. State agencies involved include education, health, human services, corrections and vocational rehabilitation. MnSIC activities, guided by statutory requirements, began in CY 2000, and during FFY 03 implementation of the IIP reached children birth to 21. Continued attention was placed on development of a web-based IIP.

### b. Current Activities

MCSHN continues to provide significant support and resources to implement the Minnesota System of Interagency Coordination ("MnSIC") process. The purpose of MnSIC is to coordinate the efforts of all state agency's systems and services, to guide local governing areas (such as IEICs) in the development of coordinated systems for children with disabilities birth to 21 years of age. A major objective is to develop an Interagency Individual Intervention Plan (IIP), for various state agencies and service systems that would incorporate the required elements of various other plans such as an Individualized Family Service Plan (IFSP) or an Individual Educational Plan (IEP). No additional funding is available for implementation of the IIP and local school districts in some cases have been reluctant to implement due to fiscal impact and concerns related to data privacy.

### c. Plan for the Coming Year

MCSHN will continue to partner with other state agencies and appropriate stakeholders to evaluate the IIP process for children with disabilities through age 21, and support and provide technical assistance to local public health on specific implementation issues.

MCSHN will continue to provide technical assistance and support to Part C, the Family Home Visiting program and the Follow Along Program. Family educational products such as MAZE, the Part C Central Directory and Parent Information Packets will be updated and distributed. As part of the activities noted in NPM #4, tracking the outcomes of legislative changes, MCSHN

will assist with watching changes in capacity and resources of community-based service systems for CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; "Promote healthy parenting/family development"; "Reduce youth risk behaviors"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Infrastructure Building).

MnSIC stands for Minnesota System of Interagency coordination, a multi agency effort "to develop and implement a coordinated, multidisciplinary, interagency intervention service system for children" from birth to 21 with disabilities. Service coordination through an Interagency Individual Intervention Plan (III-P) is encouraged for services provided by the state MCH program, IDEA, Medical Assistance (Medicaid), Developmental Disabilities and Bill of Rights Act, Head Start, Rehabilitation Services, Juvenile Court Act, Children's Mental Health Collaboratives, Family Services Collaboratives, Family Community Support Services, MinnesotaCare, Community Health Services Grants, Community Social Services Act and Community Transition Interagency Committees. MnSIC activities, guided by statutory requirements, commenced in CY 2000 and during FFY 03 implementation of the IIIP reached children birth to 21. During that time development began of a web-based IIIP.

b. Current Activities

MCSHN continues to provide significant support and resources to implement the Minnesota System of Interagency Coordination ("MnSIC") process. MCSHN activities include: 1) Technical assistance and training to local public health on transition issues, 2) Discussions related to developing transition curricula for school nurses, 3) MCSHN will actively participate on the State Transition Interagency Committee and will begin using Parent Consultants to develop and distribute transition information, 4) Minnesota Student Survey from Spring 2004 will be analyzed to identify specific risk behaviors of youth with special health care needs.

c. Plan for the Coming Year

Primary activity in 2005 will be a continuation of focus on the MNSIC process. This is especially important, as the age group 14-21 is now included. Linkages between MCSHN and Vocation Rehabilitation, the Minnesota Council on Disabilities and the Title V Adolescent Health Coordinator will be strengthened. Continue activities currently stated.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

This performance measure serving all young children is related to the state priority: "Promote family support and healthy community conditions". (Program and Resource Allocation: Direct Health Care: Population-based Services; and Infrastructure Building)

The percentage of Minnesota children between 19 to 35 months old who were up-to-date in their immunization's was estimated at 82.4 (+/- 4.9) in 2000. This represents the percentage of Minnesota children between 19 and 35 months old who had completed the 4:3:1:3:3 series of 4 or more doses of diphtheria, tetanus and pertussis; 3 or more doses of polio; 1 dose of measles-containing vaccine (essentially the same as measles, mumps and rubella); 3 or more doses of Hib; and 3 doses of hepatitis B). In 2001, this number was 76.3(+/- 5.3) for Minnesota. Both are above the national average of 72.8(+/- 0.9) in 2000 and 73.7(+/- 0.9) in 2001. Immunization data for Minnesota children at 24 months of age, in 2000 were, 80.1(+/- 6.1) for those who had completed the 4:3:1:3:3 series and in 2001 76.5 (+/- 6.0). The national levels at 24 months were 70.7 (+/- 1.1) in 2000 and 71.0 (+/- 1.1) in 2001. There has been no statistically significant change in this estimate since 1996.

The federally-funded Vaccines for Children (VFC) program began on October 1, 1994, with the goal of ensuring affordable vaccines for all children. The Immunization program of the Infectious Disease Epidemiology, Prevention and Control Division has developed an enhanced version of the program called "MnVFC" which utilizes federal VFC funding to supply vaccine for uninsured children at no cost to participating providers and utilizes federal 317 funding to provide vaccines to children whose insurance requires deductibles and/or co-pays for immunizations and vaccine for in-school clinics.

Minnesota legislation requires that all clinics that serve clients under a Minnesota Health Care Program (MHCP) such as Medical Assistance, MinnesotaCare, or General Assistance Medical Care be enrolled in the MnVFC program.

The Title V program is not the lead entity for immunization activities. In Minnesota, the Immunization, TB, and International Health Section in the Infectious Disease Epidemiology, Prevention and Control Division plans, implements and evaluates immunization activities. Title V staff collaborate with the immunization program by providing immunization training sessions to public and private providers through Child and Teen Checkup trainings.

#### b. Current Activities

Title V regularly provides information about immunizations, immunization requirements, access and availability and other immunization related information through regular newsletters such as "Healthy Children, Healthy Schools"; through e-mail newsletters such as the monthly MCH Coordinator Update, through child care health consultant, school nurse, family home visiting and other applicable listservs; through child care, home visiting, C&TC and other applicable provider trainings, and through information regularly updated and downloadable from the MDH external web site.

The Family Home Visiting Program has optional reportable outcomes related to up-to-date immunizations for age for children 0-6 and for children 0-19, dependent on their length of time in the program. Local WIC programs provide screening of key indicators of immunization status for infants/children at initial certification and all subsequent certification visits. State law requires all children in licensed childcare centers, family and legal unlicensed child care to have all immunizations up-to-date. The childcare health consultant listserv and childcare website provide parents, providers, and consultant's with information and resources on policy and program development and information about assuring currency of child immunization status.

#### c. Plan for the Coming Year

Continue activities currently stated. Work with staff from immunization program to understand if and how rates may be affected by periodic vaccine shortages.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

**a. Last Year's Accomplishments**

This performance measure serves children and adolescents and is related to state priorities: "Promote family support and healthy community conditions"; "Reduce teen pregnancy and teen birth rate"; "Address the multifaceted needs of teen parents", "Reduce youth risk behaviors" and "Improve mental health of children, youth and parents. (Program and Resource Allocation: Direct Health Care: Population-based Services; Infrastructure Building).

Approximately \$5 million in MCH Block Grant, Title X and state funds were provided through grants to local public health agencies, tribal governments and non-profit organizations for family planning services (outreach, public information, counseling and method services) with approximately one-third supporting family planning services for teens.

A Family Planning and STI hotline is also supported by state funds and is staffed by individuals trained in information and referral as well as family planning and STD counseling. Almost 5,000 calls were handled by the hotline in 2003. Information on the hotline number is mailed to Medicaid/Minnesota/Care recipients each year.

Grants activities continued under both the MN ENABL and 510 federal abstinence programs include: 1) community organization activities implemented collaboratively by community groups and interested persons to reinforce the MN ENABL message; 2) use of a curriculum consistent with established principles; 3) a media campaign promoting the abstinence message; 4) state directed training and technical assistance for community-based projects; and, 5) state and local 5 year evaluation activities which was completed in 2003. The evaluation showed an increased awareness of the abstinence program, an increased communication between parents and children, but limited sustained effect on postponing sexual activity.

Title V partnered with Department of Human Services to respond to federal questions related to Minnesota's 1115 Waiver request for family planning services.

**b. Current Activities**

The state funded MN ENABL program and the 510 federal abstinence program are operating as a single program to improve efficiency and effectiveness. Currently 23 grantees throughout the state are funded.

Grant applications were redesigned for both the MN ENABL program and the Family Planning program to focus on populations with disparities in unintended pregnancies or poor pregnancy outcomes and significant barriers to services. MN ENABL new grant cycle began in January 2003 and the new grant cycle for Family Planning grants began January 2004. During the 2003 legislative session, state funding for family planning services was decreased by \$1.2 million annually.

Title V staff have continued to assist DHS in it's on-going application for the 115 Medicaid Waiver for Expanded Family Planning demonstration project. This will significantly expand access for family planning services. The waiver will cover services for people with income at or below 200% of the federal poverty level. The Title V program will partner with the Department of Human Services in the demonstration project implementation and work to coordinate the waiver with related programs and services.

**c. Plan for the Coming Year**

Significant decreases in funding support mean coordination, collaboration and advocacy will be

necessary to preserve and continue this work. Building on existing partnerships and shared resources will be critical to efforts to reduce teen pregnancy. For example, local public health may benefit from developing stronger ties with community based Eliminating Health Disparities Initiative grantees. It will be important for Title V and Title XIX staff to work together for the implementation of the 1115 Waiver. This commitment has been made between these two agencies. There is also a growth in the partnership between these agencies to respond to the health needs of Minnesota's newest immigrants -- including the issue of teen pregnancy within these diverse cultures.

*Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

#### a. Last Year's Accomplishments

This performance measure serving children is related to the state priority "Promote family support and healthy community conditions". (Program and Resource Allocation: Infrastructure Building)

The percent of Medicaid-eligible children receiving protective sealants has ranged from 10-12% since 1996, excluding 1997 data of questionable validity. Data on protective sealants among third grade children in the general population are not available.

The Division's oral health program provided oral health training, technical consultation, and educational materials to Community Health Boards, schools and the general public and worked with the Department of Human Services in areas of dental policy and access issues.

The C&TC staff provided training sessions to C&TC providers that included discussions of dental sealants and dental assessments.

#### b. Current Activities

The Dental Health Program staff provides current, scientifically sound oral health information to individuals and groups as appropriate. Staff will work with advocates including the Minnesota Dental Association, the Minnesota Dental Hygienists Association, the Minnesota Board of Dentistry and the Minnesota Department of Human Services on the multifaceted problems of dental access.

The Minnesota School of Dentistry and Minnesota Department of Health have continued activities to establish criteria for collecting and generating Minnesota oral health data and to use internal resources as a repository for this data so it can be available to interested individuals and groups through the Internet.

Federal Oral Health Grant was awarded to the state and primary activities were targeted at oral health screening and anticipatory guidance both in WIC clinic settings and during preschool screening. It is anticipated that this additional attention to children's preventive oral health needs will ultimately improve the number of children who have received appropriate sealants.

The C&TC staff continue to provide Child and Teen Checkup training sessions which include discussion of dental sealants and dental screening.

#### c. Plan for the Coming Year

Continuation of current activities with a particular focus on data improvement and development of a Maternal and Child Health Oral Health Data Book.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

**a. Last Year's Accomplishments**

This performance measure serving children and adolescents is related to the state priority "Promote family support and healthy community conditions." (Program and Resource Allocation: Direct Service; Enabling Services; Population-based services; and Infrastructure Building).

The motor vehicle crash child death rate (birth to age 14) per 100,000 in 2001 was 2.71. Two Title V supported activities contribute to reducing risk of injury in a motor vehicle-related crash: 1) statewide distribution of car seats to those in need; and 2) intensive training of public health staff and local volunteers in the science of car seat installation. Both activities were accomplished in partnership and collaboration with Minnesota SafeKids and the Department of Public Safety. Title V funding supports local injury prevention activities and, in 2002, nearly 7,000 Minnesota children benefited from program support.

The Child and Teen Checkup (C&TC) program continued to provide training sessions to C&TC providers in CY 2002 that included anticipatory guidance on safety issues including car seats and seat belt use.

**b. Current Activities**

Continue to distribute additional car seats to those who need them; increase focus to ensure adult women, teens and children are properly restrained in a motor vehicle; and improve dissemination of information on Minnesota's seat belt law.

The C&TC program will continue to provide Child and Teen Checkup training sessions that include anticipatory guidance on safety issues including car seats and seat belt use.

We expect to see a reduction in crash death rates if health professionals continue advocating for motor vehicle safety instruction as a viable aspect of their daily responsibilities. Correct restraint needs to be modeled by parents and care givers, queried and taught by health professionals, and car / booster seats need to be provided to those who otherwise would not be able to afford them.

The Minnesota Legislature could strengthen enforcement of laws related to seat restraints, alcohol use by vehicle operators (including lowering our DUI limit to 0.08 -- passed by our Legislature this year to be implemented July 1, 2005), speed violations, and nocturnal teenage driving. Action in any of these categories would improve the health outcomes of Minnesota's children. Continued improvements in Minnesota's EMS and trauma care systems will reduce the risk of death post-crash. Minnesotans are driving more, however, thus increasing exposure to and risk of motor vehicle crash injury and/or death.

**c. Plan for the Coming Year**

Continue activities currently stated.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

### a. Last Year's Accomplishments

This performance measure, which serves mothers, is related to the state priorities "Promote healthy parenting/family development" and "Promote family support and healthy community conditions". (Program and Resource Allocation: Population-based services and Infrastructure Building).

The estimated percentage of women who breastfed their infants at hospital discharge was 79.5% in 2002 (Ross Laboratories Mothers' Survey). Breastfeeding initiation rates for some special population groups, including refugee and low-income populations, are lower. The Hmong and Somali populations have lost breastfeeding traditions, upon immigration to the United States. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. Progress continues but numerous barriers to breastfeeding remain in the general population, and immigrant populations face additional barriers.

Increasing the duration of breastfeeding continues to be a challenge. Research demonstrates a dose-response to breastmilk, with greater benefits for exclusive breastfeeding and longer durations of breastfeeding. In 2002 breastfeeding duration to 6 months was 45.1 % for the general population and 26.6 % for the low - income population. The HP2010 goal is 50%.

Breastfeeding is encouraged and supported through the Family Home Visiting program, local public health activities and information on breastfeeding has been distributed through many venues. Family Home Visiting (FHV) consultants distribute breastfeeding promotional and educational materials at site visits to the local public health agencies and the tribal governments as well as at other meetings, such as MCH Coordinators' meetings. Distribution of breastfeeding materials is also done through FHV e-mail lists and on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding, with many of the populations targeted by MCH. WIC invited a variety of community partners to breastfeeding workshops and meetings held throughout the state.

### b. Current Activities

Local public health staff, supported by MCH Block Grant funds, advocate breastfeeding and include breastfeeding promotion strategies in contacts with families through home visiting or prenatal classes.

WIC staff continues multiple activities to promote and support breastfeeding. The annual WIC Conference includes specific breastfeeding training sessions. WIC is offering a workshop on breastfeeding counseling at seven locations in 2004. WIC Breastfeeding Coordinator has participated in the 5 year MCH needs assessment process.

WIC, in partnership with other organizations, developed a Somali TV show on breastfeeding. A video from the show is being distributed to those who serve Somali clients. Plans are also moving forward related to the National Breastfeeding Campaign which will roll out in 2004.

### c. Plan for the Coming Year

Continue current activities. Continue to develop linkages to promote and support breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

### a. Last Year's Accomplishments

This performance measure serving all infants is related to the state's priorities: "Increase percent of children whose disability is identified early" and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Infrastructure).

The estimated percentage of newborns screened for hearing impairment has increased from 59.3% in 2002 to 97.2% in 2003. The measure reflects the number of hospitals participating in standardized hearing screening, rather than the direct ascertainment of infants screened. By the end of the year 2003, of the 111 birthing hospitals, 105 hospitals and 6 NICU/Special Care Nurseries reported implementation of Universal Newborn Hearing Screening (UNHS)

The 4- year SPRANS grant awarded to the state in March of 2000 supported Title V capacity to achieve the goal of universal hearing screening, especially with the need to implement a voluntary program. The Title V program was also awarded a 5- year Early Hearing Detection and Intervention (EHDI) grant from the Centers for Disease Control and Prevention in October 2000 to assist MDH in establishing a needed tracking and surveillance system. MDH tracks hearing screening results on newborns through data linkage with the state's metabolic screening program and plans to link with the infant Follow Along Program, Part C, ultimately linking with vital statistics. 16 EHDI teams have been established through cooperation with staff from Title V and the Department of Education and Human Services. Each team includes an audiologist, a teacher of the deaf/hard of hearing, and an early childhood educator. Using a train-the-trainer model, these teams train regional staff to build the capacity to better serve deaf/hard of hearing children and their families. Staff provides ongoing trainings to public health nurses, physicians and other early interventionists. MDH also subcontracts with LifeTrack Resources, a non-profit group, to develop a family-to-family support network.

#### b. Current Activities

Title V staff continues to partner with the Departments of Human Services and Education to provide state leadership in the promotion and technical support of universal newborn hearing screening. Ongoing didactic and hands-on trainings for audiologists and other providers were offered by the University of Minnesota audiology clinic faculty. Over 30 audiologists have participated in one or more trainings and six regional diagnostic and habilitative centers have been established.

The MDH tracks newborn hearing screening results via data linkage with the state's metabolic screening program. Linkages are underway with the Follow Along Program, Part C, and birth and death certificates.

Title V has continued to collaborate with Part C Coordinators, Follow Along Program nurses and staff from the Departments of Health, Human Services and Education and the University of Minnesota Department of Otolaryngology. In addition, MDH continued collaboration with LifeTrack Resources, a non-profit parent support group to assist with developing a statewide family-to-family support system and increase public awareness of UNHS. Two contract audiologists continue out reach to non-screening hospitals. The cooperative agreement from the Centers of Disease Control and Prevention is focused on development of a tracking and follow up system as well as education and training of providers.

Emphasis this past year was centered on implementing screening programs in remaining three large hospitals. Reimbursement remains an issue for long-term sustainability of a statewide voluntary screening, tracking and follow-up system. Discussions continue with the Department of Human Services about reimbursement rates for hospital-based newborn hearing screening procedures. Increased reimbursement for deliveries, to take into account newborn hearing screening, would be a significant impetus for hospitals and communities to develop and/or maintain a UNHS program.

### c. Plan for the Coming Year

Further enhancement of the data tracking and follow up system to assure that children are screened by one month of age, diagnosed by 3 months of age and offered culturally appropriate early intervention by 6 months of age. All collaborative and contractual activities will continue with a focus on provider and parent education to assure minimal loss to follow-up. Activities will focus on developing sustainable UNHS quality assurance programs for hospitals and communities.

Staff will work with hospitals that chose not to develop a hospital-based UNHS program, exploring options such as screenings in clinics, by public health nurses or contracted audiologists. As we strive for the goal of 98% of Minnesota newborns being screening, contacts have been initiated with midwives for home births and with bordering states.

### Performance Measure 13: *Percent of children without health insurance.*

#### a. Last Year's Accomplishments

This performance measure serving infants, children and adolescents is related to the state priorities: "Promote family support and health community conditions" and "Increase percent of children whose disability is identified early" (Program and Resource Allocation: Population-based Services and Infrastructure Building).

In 2002, estimates for the child uninsurance rate were recalculated for the years 1995 through 2000 to better conform with the definition of uninsurance as occurring at "some time during the previous year." This revealed that child uninsurance rates, in Minnesota have decreased from 7.7% in 1995 to 5.8% in 2000.

The Minnesota Department of Human Services (DHS) is the state Title XIX agency and the state agency that administers MinnesotaCare, and the designated Title XXI agency. Working relationships between the Title V program and DHS have been described elsewhere in this application and have been used wherever possible to influence policy decisions in the implementation and outreach activities of both the MinnesotaCare and Medical Assistance programs.

In addition, Title V program staff continue to participate on the state affiliate of the Children's Defense Fund in the CDF campaign (Covering Kids) and have incorporated into the Family Home Visiting Program strategies to decrease the number of uninsured children in the state.

#### b. Current Activities

During the 2003 Legislative session, the state of Minnesota faced a projected budget deficit of \$4.2 billion for the 2004-2005 biennium. The Governor's biennial budget request contained a number of provisions related to Medical Assistance (MA), the MinnesotaCare program and General Assistance Medical Care (GMAC). The net effect of these provisions would be to lower the income level at which most children and their families will be eligible for coverage. Children would be eligible for Medicaid coverage at or below 150% of FPG, down from 170% FPG. Children would remain eligible for subsidized coverage up to 275% of FPG. Automatic newborn coverage will be reduced from two years to one year. In addition, dependent sibling eligibility under MinnesotaCare and GMAC coverage for undocumented and non-immigrants will be eliminated. DHS estimates the net effect of these policy changes will be a reduction of the average monthly enrollment in Minnesota Care, Medical Assistance and GMAC of 168, 2,290 and 1,801 children respectively in FY04. MCH Advisory Task Force workgroup was formed to determine the impact of state budget cuts on health care coverage for children and their families and will collaborate in planning, policy and program development opportunities for

enhancing health care coverage.

The MCSHN MAZE training and 1-800 number continues to assist providers and parents to negotiate the "maze" of funding resources available for health care services. The Family Home Visiting and the WIC program assess child health insurance enrollment status. The Family Home Visiting outcome measure demonstrates a health insurance enrollment of 94% for children 0-6 yr. (exit at 0-3 mos.), and 95% for children 0-19 yr. (exit at 4-12 mos.) (2002 data)

### c. Plan for the Coming Year

Continue Information and Assistance line and Maze training activities; Monitor impact of legislative changes through the MCH Advisory Task Force activities as well as MCSHN I and A toll free line.

*Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

### a. Last Year's Accomplishments

This performance measure serving infants, children and adolescents is related to the state priorities: "Promote family support and healthy community conditions"; "Increase percent of children whose disability is identified early; and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Enabling Services; Population-based Services; and Infrastructure Building).

MDH Child and Teen Checkup (C&TC) staff provided outreach promotion activities to increase participation in MA and MinnesotaCare's C&TC program. These activities included discussions of the MA application process and forms during training for PHNs, school nurses, and county C&TC coordinators; outreach training and technical assistance to C&TC coordinators to increase their outreach to public and private C&TC providers; and advising health professionals and families about medical care funding sources during consultant visits with local public health agencies.

MCSHN continued activities aimed at increasing MA or MinnesotaCare enrollment, including, but not limited to: (1) advising families and professionals who call the 1-800 information and referral line about medical care funding sources and sending out applications for MA or MinnesotaCare as appropriate; (2) sending letters to families that apply for SSI benefits advising them they may qualify for MA if SSI eligible; and (3) providing in-service training around the state to professionals and families regarding the changing requirements and application processes for medical funding options. MCSHN continues to receive a significant number of calls involving MA, MinnesotaCare, TEFRA, and SSI eligibility, enrollment, and appeals rights.

### b. Current Activities

Title V agency staff enhance the outreach component of the C&TC program by providing technical support to local C&TC Outreach Coordinators. Staff assist in regional C&TC outreach meetings sponsored by the Department of Human Services, and participate in health plan and county C&TC Outreach Coordinator sponsored regional meetings for clinic staff and providers.

MCSHN continues to conduct outreach activities through a number of outlets. Community Systems and Development staff provide information on the Medical Assistance (MA) program through clinics and in-service training to community members, families, and professionals. The MCSHN information and assistance (I&A) line continues to provide information about medical

funding sources, including MA; and will send out MA applications to potentially eligible families who call the I&A line. Nurses staff this line and assist families in mapping out access to needed health and related services appropriate to their child's specific health concern. In addition, MCSHN continues to send out letters to families with children who are found either medically eligible or denied SSI benefits, to encourage them to apply for Medical Assistance.

Minnesota is in the process of expanding the interagency collaborative partnership established by Part C of IDEA so that all children with disabilities, birth through age 21, will have a single plan of care similar to the Individual Family Service Plan. A collaborative process at the individual level, will quickly identify children who are eligible for MA but not enrolled and those who are enrolled but not receiving health and health-related services. MCSHN has been actively involved in the development of the single plan and is currently providing training and technical assistance to local agencies. In addition, MCSHN provides resources both of staff time and at the manager level, infrastructure and capacity building, for this interagency system of services.

#### c. Plan for the Coming Year

Continue activities currently stated.

### Performance Measure 15: *The percent of very low birth weight infants among all live births.*

#### a. Last Year's Accomplishments

This performance measure serving adolescents and all women of child bearing age is related to the state priorities: "Reduce drug, alcohol, and tobacco use"; "Promote family support and healthy community conditions"; and "Reduce teen pregnancy and teen birth rate"; (Program and Resource Allocation: Direct Health Care; Enabling Services; Infrastructure Building).

The percent of very low birth weight infants remained at 1.2 in 2002. Racial and ethnic disparities, especially in low birth weight, continue to exist. Although African American low birth weight decreased in the most recent period measured from 11.5 percent (1989-1993) to 9.1 percent (1997-2001), all other populations remained the same or rose slightly, including the white population. However, the African American low birth weight rate remains more than 2 times the white rate which is 4.0 percent. Preliminary 2002 data indicate that both black and white low birth weights increased to 10.7 percent and 5.8 percent respectively. In Minnesota, Title V funds are used by Local Community Health Boards (CHBs) to carry out a variety of activities aimed at decreasing the number of low-birth weight and very low-birth weight births.

Some CHBs offer free pregnancy testing with a public health nurse who makes an initial assessment, educates and counsels about healthy behaviors in early pregnancy and refers women for appropriate services. Women who are at high-risk and income eligible at or below 200 percent of poverty or Medical Assistance eligible (275 percent of FPG) were enrolled in improved pregnancy outcome services. Due to state budget cuts, pregnant women's eligibility for Medical Assistance is scheduled to drop to 200 percent of FPG on 7/1/04. As CHBs budgets were cut in 2003, many cut back on home visiting and relied more on group education activities such as prenatal and childbirth education classes and postpartum classes on infant development, infant massage, and other parenting topics and community injury prevention activities such as car seat safety education. Other activities funded by Title V at the local level include enabling services such as the provision of transportation, translation, outreach, health education, family support services, and case management.

The Twin Cities Healthy Start program seeks to reduce the disparity in infant mortality experienced by African American and American Indian families in Minneapolis and St. Paul. It

is funded by HRSA/MCHB through 2005. The Healthy Start Collaborative, which includes representatives from Healthy Start, Title V, Title XIX, and health plans, was established to review institutional barriers, integrate perinatal services, and plan for sustainability of project efforts.

In 2003, the state legislature again funded the Eliminate Health Disparities Initiative (EHDI) which provides state dollars to local community projects to eliminate disparities in infant mortality and in seven other health areas. EHDI Infant

#### b. Current Activities

Title V staff provides technical assistance on a variety of maternal and child health activities conducted by the eleven tribes of Minnesota. An information-sharing meeting with Title V staff and key tribal staff and community members occurred in the Spring of 2003. A new Tribal Health Coordinator position located in the Office of Minority and Multicultural Health provides coordination of MDH's technical assistance to the tribes, including that of the MCH Section. The Tribal Health Coordinator, the MCH Director and several MCH staff have made joint visits to most of the 11 Indian reservations.

Title V staff provides technical assistance to Community Health Boards and other community organizations regarding improving systems to identify and refer women who are pregnant and at risk of poor outcomes. Activities include training of public health nurses and para-professionals in assessment and intervention skills related to domestic violence; alcohol, tobacco and other drug use during and after pregnancy, teen pregnancy and parenting.

Reorganization of work units within the MCH Section resulted in a Perinatal Health Unit whose primary responsibility is to implement the activities described in the 2003 Perinatal Health Plan. This unit will integrate the activities of the Infant Mortality Reduction Initiative, Family Home Visiting, preconception health, and behavioral health including substance use/abuse and will work across units with the Reproductive Health Team to reduce unintended pregnancies and improve women's health.

PRAMS data, which will be available Summer 2004, will enhance data from birth certificates adding important maternal perspectives on contributing factors for low and very low birth weight, mental health, access to care, pregnancy intendedness, social support, breastfeeding, and infant health issues such as risk reduction for SIDS and sleep safety, well child care, immunizations. These data are critically important for MCH program planning in Minnesota as we no longer have statutory authority or funding for fetal and infant mortality review projects.

#### c. Plan for the Coming Year

Continue activities currently stated-- Also see "NPM #18"

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### a. Last Year's Accomplishments

This performance measure servicing children and youth is related to the state priorities: "Promote family support and healthy community conditions"; "Reduce youth risk behaviors"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Population-based Services and Infrastructure Building).

The suicide death rate (per 100,000) among youth aged 15-19 years decreased from 10.6 in

1996 to 7.7 in 2000 and then increased to 10.3 in 2000. There were 37 deaths in 2001, and 36 suicide deaths among youth in 2002.

At the direction of the 1999 Minnesota Legislature (Ch. 245, Article 1, Section 3), the Minnesota Department of Health (MDH) conducted a study of suicide in Minnesota and, in consultation with a large group of stakeholders, developed a statewide suicide prevention plan. The plan included recommendations from the Commissioner of Health and suggested strategies from an ad hoc advisory group. This group continues to work with MDH to implement the state suicide prevention plan. In addition, workgroups were convened (i.e. K-12 Suicide Prevention Workgroup) to further refine and implement the individual strategies outlined in the plan.

In 2001, the governor recommended, and the state legislature approved, an appropriation of \$1.1 million annually to MDH to strengthen the capacity of state and local public health to work with communities to address suicide prevention.

#### b. Current Activities

During the 2003 legislative session, the suicide prevention grant program was reduced by \$123,000 per year. This impacted the number of grants that could be awarded in 2003. Also during the 2003 session the tobacco endowment supporting the Youth Risk Behavior grants was eliminated and funding returned to the general fund. This loss of funding resulted in many Community Health Boards discontinuing their activities around youth risk behaviors, including suicide prevention. MDH staff continues to work with suicide prevention grantees, local public health agencies and other statewide stakeholders to implement and document progress on the state suicide prevention plan. This includes convening, coordinating and providing ongoing technical assistance to suicide prevention stakeholders.

#### c. Plan for the Coming Year

Continue current activities as stated.

*Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

#### a. Last Year's Accomplishments

This performance measure serving pregnant women is related to the state priority: "Promote family support and healthy community conditions". (Program and Resource Allocation: Infrastructure Building)

In 2002, there were 642 births of infants weighing 1,500 grams or less. While in 2001, the percent of very low birth weight infants delivered at facilities for high-risk deliveries rose to 96 percent, in 2002 that rate dropped to 77.5 percent. (See section c)

The Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes are examples of two organizations whose purposes focus on healthy pregnancy outcomes. The Title V staff are involved with both groups in program planning for health professionals. The MPO targets all health professions involved in perinatal care by providing educational conferences to improve the health care of pregnant women and newborn infants. The March of Dimes focuses on both consumer and professional education. Title V and other health department staff work closely with March of Dimes on professional and consumer education on folic acid, preconception care, disparities in infant mortality and other birth outcomes, birth defects, and is collaborating with March of Dimes on their new prematurity education and research campaign.

## b. Current Activities

There is continuing resistance to designation and expected utilization of regional high risk care centers. Minnesota's data on this performance measure has worsened significantly. Specifically, an urban hospital with many annual births to high risk women converted from a Level III high-risk perinatal center to Level II in January, 2002. This change has negatively impact Minnesota's current data in this area.

Title V staff will monitor births of very low birth weight infants according to "Guidelines for Perinatal Care" 5th edition, 2002, published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

## c. Plan for the Coming Year

Continue current activities as stated.

*Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

## a. Last Year's Accomplishments

This performance measure serving adolescents and all women of child bearing age is related to the state priorities: "Promote family support and healthy community conditions"; Improve mental health of children, youth and parents"; and Reduce teen pregnancy and teen birth rate." (Program and Resource Allocation: Direct Health Care; Enabling Services; Population-based Services; and Infrastructure Building)

In 2002, 85.5 percent of infants were born to women receiving care beginning in the first trimester. Minnesota ranked 17th among the states and territories, Minnesota's rank for Black women starting prenatal care in the first trimester was 7th worst, at 70.0 percent. The rate for Hispanic women was 68.0 percent, 13th worst. Both Black and Hispanic rates have improved slightly since 2001. Minnesota implemented broadly inclusive efforts to improve early initiation of prenatal care and specifically target all racial and ethnic populations with culturally appropriate interventions to reduce the disparities.

In greater Minnesota, as reported by CHBs and state district nursing consultants, providers and clinics are working against these efforts to improve rates of prenatal care initiation in the first trimester by routinely instructing some of their patients to wait until their second trimester before coming in for prenatal care

Title V staff continued to work with public health agencies, representatives of managed care, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent, and early initiation of prenatal care is emphasized. Populations within the geographic district who have the lowest rate of initiation of early prenatal care are targeted to improve those rates. Examples of initiatives to improve the numbers of women who initiate early prenatal care include Twin Cities Healthy Start Project, Healthy Communities (3 counties in central Minnesota) and Integrated Prenatal Care Model (10 counties in west central Minnesota). Minnesota needs to improve efforts to reduce barriers and improve outreach for these and other populations with disparate birth outcomes, such as American Indians.

Local Community Health Boards, with Title V support, promoted the initiation of prenatal care in the first trimester, they also provided free pregnancy testing with referrals for appropriate services. Women whose pregnancy test is negative are also counseled regarding family

planning and healthy pre-pregnancy practices. See also activities previously described for NP #15 (percent of very low birth weight live births).

**b. Current Activities**

Community Health Boards continue various activities to promote the initiation of prenatal care in the first trimester. Outreach activities are fundamental to increase the number of women who will begin early prenatal care. CHBs initiate and maintain collaborative relationships with other community organizations frequented by women of childbearing age. By reinforcing the importance of early pregnancy identification and referral as well as healthy life styles to community-based organizations and the women they serve, the opportunity for impacting attitudes and behavior is increased. Community Health Boards promote such messages through collaborative agreements with area health clinics, hospitals, extension services, social services, schools, Headstart programs, and early child and family education programs.

Title V, along with the Center for Health Statistics, continues to work with Title XIX related to analyzing the Minnesota Pregnancy Assessment Form (MPAF). Since June 1998, the Department of Human Services (DHS) has required all pregnant women covered by Medical Assistance or MinnesotaCare to be screened to be reimbursed for prenatal care services. DHS data for 2001 reported in August, 2002, that out of 22,692 births, 16,537 had at least one MPAF submitted, 72.9 percent. In their report of September, 2003, covering MPAF data from 1998-2001, frequencies of risk factors and of referrals for enhanced services were reported as well as a variety of comparisons between health plans and fee for service Medical Assistance. As these DHS reports continue, it is hoped that they will add to PRAMS, Birth Certificate data, and WIC data to provide a full picture of MCH information for Title V program planning and evaluation.

**c. Plan for the Coming Year**

This performance measure is addressed in Title V's Perinatal Plan which will be implemented statewide in the coming year with the creation of a Perinatal Task Force. The Task Force will address the overarching issues leading to delays in prenatal care: pregnancy intendedness, family planning, preconception care, primary health care, and establishing a medical home.

This performance measure has a close relationship to "National Performance Measure #15: The percent of very low birth weight infants among all live births."

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Continue the expanded blood spot testing as recommended by the				

State NBS Advisory Committee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Expand follow-up activities to identified infants & their families for all additional tests	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Refine lab procedures for reducing false positive/negative test results	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Expand educational materials & activities to include all disorders identified by MS/MS screening and early hearing detection and intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Refine integrating data collection, infant follow-up & tracking with hearing screening program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Link identified infants & their families to community resources & a medical home	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop systems to help primary care physicians care for children with rare disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue active participation on the Newborn Screening Advisory Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Initiate linking blood spot and hearing data with birth/death certificates	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Develop and implement an evaluation plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Analyze evaluation of MCSHN DBC clinics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Interpret DBC analysis and formulate recommendations and implement those recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Revise objectives for Healthy Minnesotans 2010 with input & advice from parent consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue MAZE presentations made to families & professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Identify/implement strategies to involve parents & parent groups in the needs assessment process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue relationship with Family Voices for training & support of parent consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue to work with parents on revisions to the MCSHN work plan to implement the six core outcomes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Distribute medical home packets statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Continue to meet monthly with Parent Consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Explain state health department's formulation of essential public health services and determine impact on CHSCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Continue activities as outlined in the medical home grant	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. Use MCSHN clinics as opportunities to implement & support medical home concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to partner with AAP to explore methods to implement the medical home concept	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue relationship with Family Voices for training & support of parent consultants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Distribute medical home packets statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide technical assistance on medical home to local public health agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Integrate concept into all systems that come into contact with young children & their families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Distribute medical home monograph "Working with Doctors A Parent's Guide to Navigating the Health System."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Intiate efforts to integrate mental health activities into medical home activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Explore ideas for sustainability and "spread" of medical home activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Update MAZE materials to reflect changes made in the 2003-04 Legislative session	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increase the number of MAZE trainings to parents & professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Explore further analyses of data such as the National Survey on CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partner with DHS to analyze the impact of TEFRA changes on children with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to provide a toll-free number to help families locate resources	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Enhance partnerships with OMMH to evaluate access to & utilization of insurance in minority populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Use 5-year Needs Assessment process to identify emerging insurance issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Monitor proposed Medicaid eligibility and/or coverage changes submitted to 2005 Legislature.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Work with appropriate community groups to analyze proposed changes in Title XIX of XXI in 2005 Legislative session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Partner with other state agencies in the implementation of the IIP for children with disabilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Support & technical assistance to the Follow Along Program and Family Home Visiting Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Update Part C Central Directory.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Active participation in state Part C & MnSIC activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide TA & training to community partners on community based service systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work with PACER Center to revise Parent Information Packets.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Participate in implementaion of the Commonwealth/NASHP grant regarding mental health screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Assist in implementation of the DSM-DC reimbursement model for 0-3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Promote the inclusion of the SE component in the ASQ Screening Tool.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Use medical home activities to assist transitions from pediatric practitioners to adult practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increase involvement with the state AAP & explore opportunities for transition activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue active participation in the Minnesota Council on Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue staff participation in implementing the IIP, especially as the focus moves to adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop training curricula for school nurses on transition issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase parent consultants & adolescents input into the development & distribution of transition pa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue active participation on the State Transition Interagency Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Distribution of the Adolescent Health Action Plan, Being, Becoming, Belonging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Analyses of Minnesota Student Survey to determine risk behaviors of youth with CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Target information on immunizations to high-risk populations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide immunization training sessions to public & private providers through EPSDT training	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

3. Maintain & monitor as one of the performance measures for the Family Home Visiting program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assure immunization review part of WIC clinic services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Support local community immunization registries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Continue to support PRAMS data collection & analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Effective use of family planning services, including targeting Title X funds to high-risk minority teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Partner with DHS to successfully implement 1115 Waiver for family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase public understanding of the social, economic, & public health burdens of unintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop public understanding & support for policies & programs that reduce unintended pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue abstinence programs that supports adolescents in their decision to postpone sexual involvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote youth activities that support resiliency & healthy behaviors	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Support hotline for family planning & STI services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Support school-based clinics & advocate for comprehensive reproductive education	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Implement with others the state Teen Pregnancy Prevention Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Promote to dental professionals & the public the appropriate use of dental sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work to develop strategies that make it easier for children to receive sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Promote & encourage school-based/school-linked sealant programs & appropriate follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Work with the DHS to increase utilization of dental services for public program participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to incorporate preventive dental practices in the C&TC trainings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Integrate oral health anticipatory guidance into WIC clinic settings.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Develop EPSDT Training Module for oral health screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Distribute car seats	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Train car seat and booster seat checkers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Support the GDL and "Click it or ticket" campaigns of OTS, Department of Public Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support, through data analysis the shift in MN to standard enforcement of seat belts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue emphasis in Family Home Visiting and C&TC Training on home safety checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. MDH Public Health Strategies on breast feeding promotion are available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Breastfeeding promotion and support is a component of the Family Home Visiting program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC continues to provide breastfeeding education & support, ie access to breastpumps	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to provide technical assistance to local breast feeding coordinators	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Technical assistance on implementing newborn hearing screening to hospitals & communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Education & training of providers, including audiologists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Information to parents of the importance of screening & if identified with a hearing loss, additional follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Refine & expand the data tracking & follow-up system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Integrate data collection, follow-up & tracking with newborn metabolic screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Work with a variety of stakeholders on assuring follow-up, referral & intervention for infants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue federally funded grant activities in this area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Support hospital quality assurance activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

13) Percent of children without health insurance.				
1. Increase the number of MAZE trainings for parents & professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with the DHS to assure that all children eligible for public programs are enrolled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work within existing systems to assist families in identifying insurance options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to actively participate on the Cover All Kids Coalition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Update & distribute the Part C Central Directory & the Parent Information Packets	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Integrate insurance coverage as a component of the Family Home Visiting program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Technical assistance and training to communities related to eligibility criteria for public programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Consultation, technical assistance, & training regarding services provided under Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work with DHS on strategies to improve percent of children who receive a service paid by Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. One of the performance measures of the Family Home Visiting program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. 1-800 number to help families understand the public programs they may be eligible for & how to use Medicaid	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Monitor availability of Medicaid providers and enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Eliminating Health Disparities Initiative has as one of the focal areas of grantee work reducing infant mortality	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. TA to local public health & community based organizations to reduce racial/ethnic disparities in poor birth outcomes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaboration with external partners on provider & other professional education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Implementation of the Department Perinatal Health Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Utilization of PRAMS, birth & death data to plan programs & target resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide subsidized family planning services to low-income high-risk individuals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue to support Teen Pregnancy Prevention activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue activities to reduce substance use & abuse during pregnancy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Work to offer Family Home Visiting program & WIC services to all eligible pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. At local level provide services to high-risk individuals such as transportation, translation, etc.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Implementation of state suicide prevention plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Suicide prevention grants activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Technical assistance to public health & other community agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate actively on the State Advisory Council on Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to support youth activities that support resiliency & healthy behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NATIONAL PERFORMANCE MEASURE</b>		<b>Pyramid Level of Service</b>			
		<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.					
1. Monitor the status of perinatal centers in Minnesota	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Collaborate with external partners such as the March of Dimes and the MN Perinatal Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. Promote guidelines for Perinatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Monitor the number & place of birth for high-risk deliveries	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Promote maternal case manage meetings to improve maternity and infant care for diverse and low-income families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NATIONAL PERFORMANCE MEASURE</b>		<b>Pyramid Level of Service</b>			
		<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.					
1. Implement the Department Perinatal Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Support activities that focus on primary health care, family planning, & medical homes for women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. Continue involvement on the Healthy Start grant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Partner with racial & ethnic communities to identify & implement strategies for improving early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Continue partnership to develop training program for Community Health Workers through MnSCU system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6. Improve statewide universal and system capacity to provide perinatal mental health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**D. STATE PERFORMANCE MEASURES**

State Performance Measure 1: *Percent of children, birth to three, who are provided with ongoing screening for developmental or medical concerns through the Follow Along Program.*

## a. Last Year's Accomplishments

This performance measure was chosen because periodic monitoring and assessment of infants and toddlers at risk for health or developmental problems ensures early identification, support and services. The process improves the chances of identifying health or developmental problems before the child reaches school age; prevents the onset or reduces the impact of secondary complications; facilitates early intervention services for the child; affords parents support at a critical time. Public health involvement may help reduce fragmentation of services for children with special health needs. This performance measure serving infant and young children, is related to the priorities: "Promote healthy parenting/family development"; "Increase percent of children whose disability is identified early" and "Increase the percent of children who receive early intervention services". (Program and Resource Allocations at the State Level: Infrastructure building; Population-based services; Local Lever: Direct Health Care)

From 1997 through 2000 SPM #1 measured the number of local public health agencies that tracked children with identified risk factors that may lead to chronic illness/disability. Because the objective was met, the measure was changed beginning CY 2001 to reflect the number of children tracked by those agencies. During the 2001 base year the Follow Along Program provided ongoing screening to 7.1 percent of the children 0-3 years. (14,000 children screened).

Early childhood tracking is defined as periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems to ensure early identification, help, and services. To accomplish this, the Follow Along Program (FAP) has been supported by Title V as an early childhood tracking system. These activities are funded through Part C dollars at the state level and a combination of Title V and local funds at the local managing agency level.

Technical assistance to local agencies is ongoing. A software program was developed and continually enhanced to assist local agencies in the management of the program and to provide the state with an electronic download of aggregate data. Data from the Newborn Hearing Screening Program has been added to identify hearing screening results, audiological testing, follow-up, referral status and infants with risk factors for later onset hearing loss. As of December 2002 approximately 26,000 children birth to 5 were enrolled in the state's Follow Along program. This program uses the ASQ screening tool. The SE or social-emotional component of the tool was added in late 2002 at ten local public health agency pilot sites.

## b. Current Activities

MCSHN continued to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. Linkages are also being formed with the Family Home Visiting and Newborn Screening Programs. As noted, the social-emotional component was added to the ASQ tool at ten pilot sites. Data is being collected from those sites to be used in evaluation. There were more than 23,200 children actively participating in the Follow-Along Program in the six-month period ending June 30, 2003.

## c. Plan for the Coming Year

The ASQ-SE will be expanded from its ten pilot sites to all local public health agencies. Technical assistance and software enhancements will continue during 2005. The ASQ-SE will be the mental health-screening tool to be used for children under the age of three years in the Medicaid Program. MDH will provide statewide training on the use of the tool in this population.

*State Performance Measure 2: The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.*

**a. Last Year's Accomplishments**

This performance measure was chosen because periodic visits for infants and annual visits for older children and adolescents is one of the best methods for detection of physical, developmental, behavioral or emotional problems so appropriate treatment can be given, as well as providing opportunities for health promotion and disease prevention and education. This measure serving children and adolescents, is related to priority need "Increase the percent of children whose disability is identified early"; Improve mental health of children, youth and parents"; "Increase the percent of children who receive early intervention services". (Program and Resource Allocation: Direct Services, Enabling services, Population-based Services and Infrastructure Building)

In Minnesota the Title XIX EPSDT program is called C&TC (Child and Teen Check-ups). The percentage of children and adolescents who were enrolled in public programs who received comprehensive, preventive health visits increased by 1% from 2002 to 2003 to a rate of 60%. In general, the data indicate many lost opportunities for the provision of preventive care to these population groups.

Under contract with the Department of Human Services (DHS), Title V staff offered an extensive schedule of C&TC training sessions to health care providers. Participants included public health nurses, private providers, and C&TC Outreach Coordinators. On-site follow-up consultations and clinic flow assessments were provided by a MDH certified pediatric nurse practitioner for newly trained nurses and refresher training was offered to more experienced nurses.

**b. Current Activities**

Title V continues to collaborate with DHS in the planning, development and evaluation of the components and standards of the Child and Teen Checkups Program (Minnesota's EPSDT program). Through formal and informal relationships with DHS, Title V provides technical support to public and private Child and Teen Checkup providers, and to Outreach Coordinators in their efforts to inform clients and providers regarding C&TC. Also, Title V provides statewide training for Medical Assistance providers to increase quality comprehensive preventive health visits. Child and Teen Checkup training sessions continue to be updated regularly and are offered for public and private providers focusing on standards and screening components such as anticipatory guidance.

Preventive health care health services, based on the "Guidelines for Adolescent Preventive Services" model, were provided to children and adolescents in community and school-based clinics in Minneapolis and St. Paul. These services reach a population of urban youth who are at high risk for health problems, have inadequate financial access and are underserved in the traditional health care system. Title V funds supported the health services provided to 16,721 children and youth in CY 2003.

Title V continued collaboration with professional organizations, educational programs/institutions, state and local agencies, health plans and related childhood health programs to promote quality preventive care for Minnesota Children. Title V collaborates with the Department of Human Services (DHS) in the planning, development and evaluation of the components and standards for the C&TC. Local health care leaders including Title V staff have participated in the Cover All Kids Coalition to promote health care coverage and preventive care for Minnesota children. Members of the public-private coalition have been working together to increase public awareness of insurance options for children, find new ways to

reduce health disparities, and make it easier for parents to get preventive care for their children. The interagency partnership between Title V, DHS, the Department of Education, and the Minnesota Head Start -- State Collaboration Office has increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits (i.e. C&TC, Early Childhood Screening, Head Start). Activities include joint regional screening workshops and the development of the Minnesota Child Health and Developmental Screening Quality Indicators; A Comprehensive Framework to Build and Evaluate Community Based Screening Systems. To further collaboration regarding comprehensive preventive care, Minnesota was awarded the Maternal and Child Health Bureau's State Early Childhood Comprehensive Systems Planning Grant. The primary goal of the grant is to develop a state plan for an integrated comprehensive early childhood screening system.

c. Plan for the Coming Year

Continue activities currently stated.

State Performance Measure 3: *Incidence of injury (violence/unintended; fatal/non-fatal) to all MCH populations.*

a. Last Year's Accomplishments

This performance measure was chosen because unintentional injury and violence are the leading causes of morbidity and mortality in children and youth of both genders, and among women through the age of 34 in Minnesota. Injuries are sometimes the result of inadequate nurturing/supervision of children, unhealthy environments and risk-taking behavior. Injuries are the leading cause of death, hospitalized injury and emergency department-treated injury among children aged 1-19. This measure affects all MCH populations and supports priority need "Promote family support and healthy community conditions;" "Reduce youth risk behaviors;" and "Reduce child abuse and neglect." (Program and Resource Allocation: State Level: Enabling Services, Population-based Services, and Infrastructure Services. Local Level: Direct Health Care).

The incidence of MCH-related injury has ranged from about 300 to nearly 400 per 100,000 population since data became available in 1998. An index score of injury to all MCH populations increased to nearly 400 in 2002. (The index injury score is calculated by summing fatal and non-fatal injury and violence rates across all MCH sub-population age groups.)

For unintentional injury, the principal activity and investment of staff resources have focused on reducing the risk of unintentional injury in homes where young children reside. The Home Safety Checklist, refined and evaluated in Minnesota in the early 1990s, is used to identify environmental risks and is the teaching tool for ongoing home monitoring. Other activities include support for community-based activities on the correct use of child restraints in motor vehicles. These activities are supported with Community Health Boards through Title V funding. In 2002, over 62,000 children were reached. The Home Safety Checklist has been included as part of the Family Home Visiting Program protocol.

The principal manner of addressing and responding to violence in communities across Minnesota is to train local public health community members to analyze local data, assess community needs, and implement and evaluate control and prevention programs. While "hands on" technical assistance to communities continues to be provided, data and training materials are being disseminated via the web.

The Injury and Violence Prevention Unit maintains the statewide Traumatic Brain and Spinal Cord Injury Registry, the state trauma data bank, the hospital emergency department injury

surveillance project, and supports other special injury and violence-related data initiatives. This capacity for data collection and analysis will generate refined performance measurements for each evaluation period.

The MDH Sexual Violence Prevention Program helps to sustain the work of sexual assault programs across the state and, through the state public health system, to build capacity to respond to and prevent sexual violence. Activities initiated by MDH include the dissemination of the program's resource kit.

#### b. Current Activities

Bicycle helmet and seat belt use are promoted, smoke alarm installation is encouraged or accomplished, safe storage of firearms is exhorted, and the Home Safety Checklist is utilized among families with young children. These activities also prevent traumatic brain and spinal cord injuries. Title V funds are used to support childhood injury control activities of local public health agencies. Community health professionals use the Home Safety Checklist, analyze local data, assess community needs, and implement and evaluate control and prevention programs. The Sexual Violence Prevention Program offers training and advocacy support, and distributes prevention materials across Minnesota.

State priorities affect the degrees to which communities are able to institutionalize or even respond to injury and violence prevention as local public health priorities. In addition, the tenant of honoring local decision-making means that the community may select, in the short term, public health priorities other than those relating to injury and violence prevention. To support local decision-making, the MDH publishes current county level injury and violence data (paper and web-based), which buttress the development of local policies and programs relating to injury and violence prevention.

#### c. Plan for the Coming Year

MDH Staff will continue to collect, analyze and disseminate data for local and state providers / planners. Data will be disseminated via the web and paper copies. Reports of best practices in the prevention of unintentional injury and youth violence will be distributed and training and technical assistance provided. Emphasis will also continue through C&TC trainings and the Family Home Visiting Program to reduce the incidence of injury in MCH populations

### State Performance Measure 4: *Incidence of substantiated child maltreatment by persons responsible for a child's care*

#### a. Last Year's Accomplishments

This performance measure was chosen because child maltreatment has devastating effects on its victims. While Minnesota's rate of substantiated child maltreatment is relatively low, children with disabilities are nearly twice as likely as their same-aged non-disabled peers to be victims of maltreatment. In addition, there is a 10-fold difference in likelihood of maltreatment between the lowest risk racial group (Asian) and the highest risk racial group (African American). Maltreatment is the antithesis of adequate nurturing. This measure affects children and adolescents and supports priority "Reduce child abuse and neglect". (Program and Resource Allocation: Enabling Services; Population-based Services; Infrastructure Building).

Substantiated child maltreatment by persons responsible for a child's care stayed consistent at 7.2 incidents per 1,000 children (0-17) in 2001 and 7.3 incidents per 1,000 children (0-17) in 2002. When the Alternative Response Program is used, cases do not receive a determination of substantiated abuse/neglect and thus are not counted in the state incidence rate.

Child maltreatment has been identified as an important public health issue in the Minnesota Public Health Goals and its associated strategies document. Title V staff provided significant expertise in the development and revisions of these documents. This work serves as a guide to community health plans and others committed to improving public health. This information, along with other strategies to achieve the objectives of reducing child maltreatment, has been disseminated through statewide training and technical assistance to local public health agencies. Title V agency activities have focused on funding local home visiting programs and state program administrative and technical support.

State and federal TANF funds were available to Community Health Boards (CHBs) and Tribal governments for home visiting services to families at or below 200% of the poverty level or for teen pregnancy prevention activities. Thirty-five counties and one tribe selected pregnant/parenting teens as their target population and twenty-two counties and one tribe identified prevention of child abuse and neglect as an optional outcome. The MDH Family Home Visiting team continues to provide technical assistance, training and evaluation assistance.

Nursing Child Assessment Satellite Training (NCAST) sessions were provided to public health nurses by Title V staff. NCAST training offers health professionals in-depth training in the use of caregiver-infant/child interaction assessment scales. Scales included in the training are the, SAR (Sleep Activity Record), the NCAST Feeding Scale, and the NCAST Teaching Scale. These scales are a reliable and valid means of observing and rating caregiver-infant/child interaction for the purpose of assessing whether the caregiver and child have problems in their interaction and communication pattern. NCAST's often used in managing child abuse.

## b. Current Activities

Ongoing technical assistance and consultation is provided for local public health or tribal government's home visiting program staff. This includes on-site visits (regional and upon request) and interactive video conferences, and a Family Home Visiting website makes available home visiting strategies and best practices, training resources, home safety resources, evaluation summaries, guidelines and program updates.

Beginning in FY 2004, Family Home Visiting is included as one of the programs within the Local Public Health (LPH) Act and public health nursing home visitation is one of the essential activities under the LPH Act. The three funding sources under the LPH Act for CY 2004 include state general funds, MCH Block Grant funds, and federal TANF funds totaling \$31,309,000 for the CHBs and \$1,500,000 for the Tribal Governments. Local agencies determine their own priorities for use of these funds within the respective funding guidelines. All three sources of funds under the LPH Act can be used for provision of family home visiting services depending on local needs and priorities. Technical assistance and consultation is provided for local CHB and Tribal Government Family Home Visiting Program staff. Staff continue to provide Nursing Child Assessment Satellite Training Sessions (NCAST) and support in using such tools to community public health nurses. The NCAST scales are used to assess parent-child interaction during feeding and teaching events.

In February, 2004, Family Home Visiting collaborated with the Infant Mortality Reduction program, the Injury and Violence Prevention Unit, and the Midwest Children's Resource Center of Children's Hospitals and Clinics to implement a new Shaken Baby Syndrome prevention and education project. Using Title V funds, education for professionals and paraprofessionals was provided via interactive video conference and parent education materials and education protocols are being disseminated throughout the state to local public health and other agencies serving families with newborns. In April, 2004, Family Home Visiting staff participated in planning for the 2004 Child Abuse Prevention Conference sponsored by Prevent Child Abuse

Minnesota.

c. Plan for the Coming Year

Continue activities currently stated.

State Performance Measure 5: *Percent of pregnancies that are unintended.*

a. Last Year's Accomplishments

This performance measure was chosen because pregnancy intendedness is directly related to pregnancy outcome, infant mortality and child health outcomes. This measure affects adolescents and women of child bearing years and supports priorities: "Promote family support and healthy community conditions"; "Promote healthy parenting/family development"; "Reduce teen pregnancies and teen birth rate"; "Address multifaceted needs of teen parents"; and "Reduce youth risk behaviors." (Program and Resource Allocations: Direct Health Care; Enabling Services; Population-based Services; and Infrastructure Building)

Baseline data was collected in 1999 as part of the state's Behavioral Risk Factor Surveillance System (BRFSS). Unintended pregnancy was estimated at 43 percent. This figure was mirrored in the initial analysis of 2002 PRAMS data.

Both Title V, Title X and state funds are expended for family planning services, including method services. In 2003, local CHBs used Title V funding to provide family planning method services to 3,180 individuals. In SFY 2004, \$4.9 million in state dollars support the Family Planning Special Projects (FPSP) grant program and funded 40 programs and one hotline. These funds are available to Community Health Boards, Tribal Governments and non-profit corporations to provide pre-pregnancy family planning services. In CY 2003 the FPSP grant program served 23,626 women for family planning method services. MDH also received Title X funds for an expansion project to provide family planning services to minority youth in high risk neighborhoods of South Minneapolis. During the past year, approximately 1,300 adolescents received family planning services.

b. Current Activities

Both Title V, Title X, and state funds continue to support family planning services including family planning method services. During the 2003 legislative session state funds were reduced by \$1.2 million beginning in SFY 2005. Tentative federal approval for Minnesota's 1115 Waiver request for the provision of family planning services has been received. Final negotiations continue and efforts are being directed at implementation activities. This waiver would allow individuals with incomes up to 200 percent of FPL to obtain coverage of family planning services.

c. Plan for the Coming Year

Continue current activities as stated. In partnership with the Minnesota Department of Human Services and other stakeholders, planning for implementation of the 1115 Family Planning Waiver will be a major focus on program activity this year. In order to maximize the effectiveness of the 1115 Waiver, study of Title V family planning activities; Title X and FPSP activities will be needed. We will use our new resource of PRAMS data to track this issue.

State Performance Measure 6: *Percent of women who use alcohol, tobacco and other*

#### a. Last Year's Accomplishments

This performance measure was chosen because health professionals concur that tobacco, alcohol and other drug use during pregnancy is injurious to the fetus and profoundly affects pregnancy outcomes. This measure affects all women, especially pregnant women and supports priority needs: "Reduce drug, alcohol and tobacco use" and Reduce youth risk behaviors". (Program and Resource Allocation: Enabling Services; Population-based Services; and Infrastructure Building).

Title V staff were involved in a number of activities intended to reduce alcohol, tobacco, and other drug use during pregnancy, including: 1) Analysis of the Minnesota Pregnancy Assessment Form (MPAF). This form asks providers to assess medical and psychosocial factors that contribute to poor birth outcomes. Among the 40 items assessed are questions regarding tobacco, alcohol, and/or other drug use during pregnancy. Since June 1998 the Department of Human Services has required all pregnant women covered by Medical Assistance and/or MinnesotaCare to be screened using the (MPAF) to be reimbursed for prenatal care services. It is estimated that of the 22,692 deliveries in 2001 covered by Medical Assistance, 16,537 or 72.9 percent, were screened prenatally using the MPAF. 2) Activities of the FAS Program have primarily concentrated on intervening in women's alcohol use in pregnancy around the state. The three major components of this effort include a grants program, a mandated professional education and curricula development project, which has been completed, and a public information and media campaign, completed in 2003. 3) The results of a needs assessment prompted MDH to subscribe to a clinician's toll free phone line for information about patient drug exposure, prenatal exposures to alcohol and other chemicals, and pregnancy management advice. 4) MCSHN offered a number of statewide FAS/FAE diagnostic clinics. 5) Staff has developed a Women and Substance Use in the Childbearing Years Prevention Primer. The Primer is a new tool to prevent the devastating effects of alcohol, tobacco and other drugs on women and children. Developed by public health educators and nurses. It serves as a guide for client and community prevention educators and planners in a variety of practice settings. It encompasses risk factors such as domestic and sexual abuse and mental health issues and how they intersect with substance use/abuse. It is both a compendium of recommended education resources and a prevention planning guide.

#### b. Current Activities

Staff are currently 1) disseminating best practice information and resources to local public health, WIC clinics, tribal health, community-based organizations, and providers to help pregnant women stop smoking, prevent post partum relapse, and encourage use of Minnesota's telephone QuitPlan. 2) C&TC provides Child and Teen Checkup (EPSDT) training sessions with instruction on health history questions specifically regarding alcohol, tobacco and other drug use. 3) Transitioning FAS training curricula to the web. 4) Continue to collaborate with others to assure an integrated state system of reducing the number of pregnant women who use or abuse chemicals during pregnancy. 5) Participate on the project "Reducing Tobacco Abuse Among Pregnant American Indian Women" lead by the Indigenous People's Task Force. This project combined existing quantitative data from birth certificates and the WIC program with qualitative data generated by community researchers in order to determine what contributes to the apparent high smoking rate of pregnant American Indian women and what strategies the community could use to reduce that rate. 6) In early 2004, staff was invited to apply for technical assistance from AMCHP, ACOG, PPA, and the CDC to create a state partnership on smoking prevention and cessation for women of reproductive age. Minnesota's application was selected and a state team including the Title V staff team leader, staff from MDH's Tobacco Prevention and Control Section, the state chair of ACOG, and the policy director of Planned Parenthood of MN/SD attended the training in Washington,

DC and developed a state partnership plan. 7) Monitor and provide technical assistance to FAS grantees. 8) Conducted 57 neurodevelopmental evaluation clinics in 12 out-state cities. 9) Public information efforts focused on messages for populations of color. Focus group research led to development of the campaign's creative concept "Drinking during pregnancy is a risk to a woman's health and her baby's health. Are you willing to take that risk? Help pregnant women stop drinking during pregnancy because the stakes are too high." 10) Disseminating the Women and Substance Use in the Childbearing Years Prevention Primer described above. 11) The Department received a 5 year CDC grant in October, 2003, for FAS Prevention. The purpose is to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking in women 18-44; to increase contraception use in women 18-44; to increase data collection and use on women's drinking and contraception use; and to prevent and reduce FAS in targeted prenatal and preconceptional populations at risk for binge and prenatal drinking.

### c. Plan for the Coming Year

Reorganization of work units within the MCH Section resulted in a Perinatal Health Unit whose primary responsibility is to implement the activities described in the plan. This unit will integrate the activities of the Infant Mortality Reduction Initiative, Family Home Visiting, preconception health, and behavioral health including reducing and preventing substance use/abuse in pregnancy and will work across units with the Reproductive Health Team to reduce unintended pregnancies and improve women's health. Continue activities currently stated.

## State Performance Measure 7: *Inactive*

### a. Last Year's Accomplishments

The Collaboratives are intended to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hopes to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. The Collaboratives are intended to support parents in their roles as nurturers of children; promote healthy environments and facilitate access to services.

### b. Current Activities

The Department of Human Services, Children's Services Report to the 2003 Minnesota Legislature, *The Role of Collaboratives in the Children's Mental Health System*, describes the three major contribution of the collaboratives to the children's mental health system as: 1) increased funding flexibility; 2) increased family and community involvement and 3) increased cross agency planning and service delivery, in particular between the county and schools. Integrated funds, pooled local, federal and state resources, have provided non-categorical, flexible funding for children's services, including mental health services. Parent and family participations in the governance and work of collaboratives are a significant and positive result of collaborative activity and collaboratives have brought new programs and service delivery methods to communities across Minnesota.

### c. Plan for the Coming Year

This measure was inactivated as the state reached their objective.

## State Performance Measure 8: *Inactive*

### a. Last Year's Accomplishments

This performance measure was chosen because while enjoying overall good health status, Minnesota has some of the worst racial/ethnic disparities in health status in the country. (Program and Resource Allocation: Infrastructure building services)

### b. Current Activities

### c. Plan for the Coming Year

This performance measure was inactivated as the state's objective was met.

## State Performance Measure 9: *Children with disabilities place in out-of-home placement due to disability.*

### a. Last Year's Accomplishments

This performance measure was chosen because one of the ongoing significant goals for children's programs in Minnesota has been the development of a community-based, family-centered system of care for children with chronic illness and disabilities. We believe that children with disabilities belong in loving families in their own communities and that federal and state resources should be made available to support families in their efforts to maintain their children at home. Over the last 3 years, many of the state and federal resources used to support these efforts have been threatened. This measure affects children with special health care needs and supports the state's priority needs: "Promote family support and healthy community conditions"; "Promote healthy parenting/family development"; "Reduce child abuse and neglect"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Direct Health Care, Enabling Services; Population-based Services and Infrastructure Building).

The rate of children entering out of home placement due to a disability increased slightly, withstanding systems trends that would be expected to have caused a greater increase. Children with special health needs, once placed out of home are significantly less likely to return to their families than their healthy peers.

The major activity surrounding this performance measure included the survey analysis and dissemination of a report based on research regarding the home care needs of children with special needs. Previous studies have shown that lack of resources to care for children with special health needs are a risk factor for out of home placement. "Pediatric Home Care in Minnesota" examined the current status of home care in Minnesota and gathered input from families for improving the current system.

MCSHN staff continued to ensure families and care coordinators are aware of and understand how to access services and supports to assist families in maintaining their children at home. MCSHN coordinates a listserv intended to identify barriers and propose solutions to community-based supports for children with special needs. Staff continued leadership roles in the development and implementation of a coordinated, interagency birth -- 21 system of services for children with disabilities. Training and technical assistance materials designed to clarify funding streams for community-based services were redesigned. On-going technical

assistance and training were provided to parents and a variety of professional groups through the Information and Assistance line as well as MCSHN District office staff.

#### b. Current Activities

A web-based Central Directory of Early Childhood Services went on-line during the last year. Hard copies were made available to local agencies and pediatricians participating in Minnesota's Medical Home Project. 1,300 families of CSHCN and professionals involved with this population received training on financial resources available in order to prevent or delay out of home placement. Information and Assistance services were provided to more than 1,500 persons concerned with CSHCN. MCSHN provided information and input in the design and feedback on the outcome of the Legislative Auditors Report on Medicaid Home and Community-based waived services for persons with mental retardation or related conditions.

#### c. Plan for the Coming Year

Most, if not all, of the current activities will be carried over to FFY2005. MAZE materials will continuously be updated; the Central Directory is updated continuously and services added as they become available. Information and Assistance activities will continue as well as efforts in the interagency coordination process to increase the number of children who have an Individual Interagency Intervention Plan.

*State Performance Measure 10: The percentage of children birth through 21 years of age eligible to have an Individual Interagency Intervention Plan (IIIP) who have a IIIP.*

#### a. Last Year's Accomplishments

This performance measure was chosen because it supports a coordinated family centered community based system of care. This performance measure supports the state's priority need "Promote family support and healthy community conditions" and "Increase the percent of children who receive early intervention services". (Program and Resource Allocation: Population-based Services, Infrastructure Building).

This performance measure was new in the last reporting period. During FFYs 2001 and 2002 a major effort was undertaken to develop a system of interagency coordination of services for children with disabilities. Modeled after the state's experience with Part C and the Individual Family Service Plan for children 0 to 3, the IIIP is targeted for children receiving Special Education Services and services from another state agency. Beginning in 2000 and 2001, IIIPs were developed for children with a special health care need birth to 5 and then expanded to children birth to 9. As of July 1, 2003 the IIIP is available to children up to age 22. It is voluntary on behalf of both families and local agencies.

#### b. Current Activities

Staff from the state's agencies most affected by this legislation have developed policies and procedures governing this activity and collaborated on providing technical assistance needed to local community (school, public health, human services, corrections and vocational rehabilitation) agencies. Web based version has been piloted in a number of communities and work on the evaluation component continues.

#### c. Plan for the Coming Year

Current activities currently stated. If more accurate data is not available from the Department of Education this measure will be discontinued.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of children, birth to three, who are provided with ongoing screening for developmental or medical concerns through the Follow Along Program.				
1. Provide technical support to local public health agencies who participate in the program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Advisory group to guide implementation of program enhancements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Integrate social emotional component into all screening programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Upgrade software to facilitate & streamline program activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Analyze program data & disseminate written report	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Explore integration of tracking system with other follow-up or home visiting programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Statewide training on reimbursement & funding sources & effective assessment & intervention	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Assist other entities, such as Human Services, in training professionals on ASQ-SE.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percentage of children and adolescents enrolled in health plans who receive comprehensive preventive health visits according to nationally accepted standards.				
1. Maintain & monitor as a performance measure for the Family Home Visiting Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Distribute the Adolescent Health Action Plan: Being, Belonging, Becoming	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue joint activity with the DHS as it relates to the Medicaid enrolled children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide TA to local public health agencies to improve number of children receiving EPSDT screenings.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Continue to incorporate anticipatory guidance into WIC & MCSHN clinic activities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide technical assistance & training to a variety of key providers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Maintain & enhance partnerships with other organizations who to are working assure children's quality care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develop State plan for an integrated and comprehensive early childhood system to assure all children 0-5 are screened and referred.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Incidence of injury (violence/unintended; fatal/non-fatal) to all MCH populations.				
1. Prepare linked data sets to assist partners in understanding county costs of injury/violence	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Analyze & disseminate injury & violence mortality data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analyze & disseminate injury & violence hospital in-patient data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analyze & disseminate injury & violence hospital emergency department data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Assist & support local public health & other community entities in understanding data	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Distribute Sexual Violence Prevention Resource Kits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Develop and disseminate training materials	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Provide and support the use of the Home Safety Checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Use data in developing state policies & programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Incidence of substantiated child maltreatment by persons responsible for a child's care				
1. Maintain & monitor performance measure for TANF funded Family Home Visiting Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue involvement of Infant/Child Death & Child Maltreatment Review Panels	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop/update & distribute infant death investigation guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide information to local health & other partners regarding available crisis services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Disseminate strategies for prevention of child maltreatment ie home visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Continue to provide NCAST training	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of pregnancies that are unintended.				
1. Analyze PRAMS data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Efficient & effective use of state funds (\$3.7 million) a year for family planning services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Target Title X funds to high-risk minority teens	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partner with Department of Human Services to successfully implement 1115 Waiver for family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Increase public understanding of the social, economic, public health burdens of unintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Develop public understanding & support for policies & programs that reduce unintended pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote statewide implementation of abstinence based education for 12 to 14 years olds	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Implement youth activities that increase resiliency & support healthy behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Continue to direct resources to a hotline for family planning & STI services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Support school-based clinics & advocate for comprehensive reproductive health education	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of women who use alcohol, tobacco and other drugs during pregnancy.				
1. Continued use of the MN Pregnancy Assessment Form	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Enhance data collection & interpretation of MN Pregnancy Assessment Form	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Work toward data matches between MN Pregnancy Assessment Form (Medicaid) & Birth & Death records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Begin to analyze PRAMS data.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue implementation & evaluation of FAS prevention activities.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide technical assistance to community FAS service providers & grantees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Create and maintain a statewide partnership of organizations addressing tobacco cessation for women of child bearing age.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8. Provide Teratogen info & management line for state clinicians	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Increase provider education & dissemination of tools for smoking cessation during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Develop integrated assessment in WIC clinics & Family Home Visiting Program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Inactive				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Inactive				
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Children with disabilities place in out-of-home placement due to disability.				
1. Prepare & distribute MAZE training materials for use in local agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assure that families have access to the support & services they need.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue the MCSHN 1-800 number to assist families in locating services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assure that families have a coordinated plan of care through the IIIP.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partner with DHS to identify strategies to reduce out-of-home placement.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Continue to enhance and develop appropriate transitive systems.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The percentage of children birth through 21 years of age eligible to have an Individual Interagency Intervention Plan (IIIP)				

who have a IIIP.				
1. Develop needed policies to implement legislative requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide technical assistance & training to local county & state agency personnel	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Fully participate & staff MnSIC advisory groups, work groups & State Interagency Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop & print needed written manuals on system components & intra-agency coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop evaluation strategies, indicators & methods for implementation at state & local levels	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Assure that local public health is fully participating in plan development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote utilization of III-P among families, special ed teachers, and county social service personnel.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

### A. Toll-free Telephone Number

For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. The Title V MCSHN Section has operated a toll-free Information and Assistance telephone line since March of 1990. The toll-free number is 800 728-5420. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and informational publications developed and distributed by MCSHN and is included in all media announcements. MCSHN staff operating this line have also taken on increased responsibilities for following up on children identified through newborn screening and expect to increase that work as Minnesota enhances it's activities around a Birth Defects Information System.

2. Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health programs and other maternal and child health matters are referred to Title V. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS internet web sites.

3. The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. The number is (651) 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The line handle about 200,000 calls per year.

4. The Minnesota Family Planning and STD hotline is funded through state appropriations. The hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. The number is 800-78-FACTS. In 2003, approximately 4,900 calls were handled by the hotline. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients.

5. The WIC Program (Women, Infants and Children) 800 number is funded through Minnesota's federal WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the local WIC project in their geographic area. The toll-free number is 800-WIC-4030. The service responds to approximately 3,300 calls per year. All WIC outreach materials distributed by the state WIC office and the local projects include the 800 number. There is also a WIC supported specialized line related to breastfeeding (877-214-BABY).

6. The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The toll-free number is 800 657-3970. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers faced with the increasing complexities of immunizations.

#### B. Title V- Title XIX Coordination

The MDH assures that the Minnesota Title V programs will participate in the arrangement and carrying out of coordination agreements with the Title XIX program administered by the Minnesota Department of Human Services. As evident throughout the application, the extent of collaboration between the Medicaid program and the Title V programs in Minnesota is considerable. The formal interagency agreement between the agencies has been designed to facilitate response to the rapidly changing health care services and delivery system in Minnesota. Managers responsible for children's programs at the Minnesota Department of Health and the Minnesota Department of Human Services (DHS) meet quarterly to discuss matters of mutual concern.

## F. TECHNICAL ASSISTANCE

During FFY 2003, a request for technical assistance was submitted to the Association of Maternal and Child Health Professionals (AMCHP). This request was to assist the Title V programs and the WIC program in developing a strategic plan for a data infrastructure that would support program activities. This request was funded and with the assistance of two trainers from John's Hopkins University and AMCHP portions of CAST-5 activities was implemented. We have again submitted a request to AMCHP for continued funding to complete CAST-5 tool and have been recently notified that we will be receiving additional but reduced funding from AMCHP to continue our capacity building in the data area.

While the technical assistance provided through AMCHP will cover some of the components relating to continuing our work with the CAST-5 tool, Minnesota is interested in completing this tool in its entirety for all capacity areas and is requesting technical assistance from the Maternal and Child Health Bureau to support facilitation of the remainder of the components.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

Please see Forms 3-5 that describe all Minnesota's state expenditures. Effective 7/1/03 a new Local Public Health Act and related block grant was implemented. At the same time there was a reduction in some dollars, there was increased flexibility for locals to direct dollars towards their priorities. We expect this has affected and will continue to influence expenditures towards MCH activities. Two attachments are provided here for further detail.

### **B. BUDGET**

Variations of 10 percent or more between budgeted amounts and expended amounts have been noted on the note sections of Forms 3-5. Generally, the expended amount is less than what was budgeted because of overall under expenditure on salaries due to restrictions and delays in hiring positions. Positions that remained open longer than anticipated also affecting the spending patterns for supply budgets and indirect charges.

Other sources of federal funds come from the Maternal and Child Health Bureau (MCHB), the Centers for Disease Control and Prevention, the Department of Agriculture, and the Department of Education. MCHB supports the State Systems Development Initiative, Abstinence Education, Genetics, and Universal Newborn Hearing and Screening, Comprehensive Health Care for Women, and Medical Home Development programs. The Centers for Disease Control and Prevention funds the Preventive Block Grant, the Pregnancy Risk Assessment Monitoring System (PRAMS) project, Universal Newborn Hearing Screening and FAS activities. The Department of Agriculture supports the Supplemental Nutrition Program for Women, Infants and Children (WIC) program and the Commodity Supplemental Food Program (CSFP). The Department of Education funds the Part C program. It should be noted that while the Division of Family Health is the recipient of all the funds described above, not all of the funds are administered by the MCH or MCSHN Sections. The Supplemental Nutrition Programs Section administers a portion of these funds. However, all the funds impact the MCH population and are under the control of the Family Health Division Director.

The sources of matching funds include the state General Fund, the greatest of which include state Local Public Health Grant, local tax revenues and Medical Assistance reimbursements. State General Fund dollars also support additional MCH-related activities such as the Infant Mortality, MCSHN clinics, the Fetal Alcohol Syndrome Initiative, The Family Home Visiting Program, and Suicide Prevention.

Minnesota's maintenance of effort from 1989 is \$6,184,197. The budget documents that Minnesota has exceeded this level of effort.

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.